DentaQuest of Georgia, LLC

Please Refer to Your Participation Agreement for Plans You are Contracted For

Amerigroup Community Care

Medicaid Office Reference Manual

11100 W. Liberty Drive Milwaukee, WI 53224 800.516.0124
www.dentaquest.com

DentaQuest makes every effort to maintain accurate information in this manual; however will not be held liable for any damages directly or indirectly due to typographical errors. Please contact us should you discover an error.

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DentaQuest of Georgia, LLC Address and Telephone Numbers

Provider Services
800-516-0124 11100
W. Liberty Drive
Milwaukee, WI 53224

Eligibility or Benefit Questions:
800.516.0124
Fax numbers:
Claims/payment issues: 262.241.7379
Claims to be processed:
262.834.3589
All other:
262.834.3450 Claims
questions:
denclaims@dentaquest.com

Customer Service/Member Services
DentaQuest Amerigroup 800.895.2218
Peach State 800.704.1484

Fraud Hotline
800.237.9139

TTY/TDD
Amerigroup 711 relay
Peach State: 800.255.0056

Multilingual
Amerigroup [insert phone number]
Peach State 800.704.1484

Provider Claim Appeals should be sent to:
Provider Claim Appeals
11100 W. Liberty Drive
Milwaukee, WI 53224
e-mail:
Providerclaimappeals@dentaquest.com

Credentialing
11100 W. Liberty Drive Milwaukee, WI 53224
Credentialing Hotline: 800.233.1468 Fax:
262.241.4077

Authorizations should be sent to:
DentaQuest of GA -
Authorizations 11100 W. Liberty
Drive Milwaukee, WI 53224

Prior authorizations for Operating Rom should be sent to:
DentaQuest of GA -OR Authorizations 11100
W. Liberty Drive Milwaukee, WI 53224 e-mail:
GAIVSedationRequests@dentaquest.com

Paper Claims should be sent to:
DentaQuest of GA-Claims
11100 W. Liberty Drive
Milwaukee, WI 53224

Electronic authorizations should be sent:
Via the web -www.dentaquest.com Via
Clearinghouse DentaQuest 11100 W. Liberty
Drive Milwaukee, WI 53224

Electronic Claims should be sent:
Direct entry on the web – www.dentaquest.com
Or, Via Clearinghouse – Payer ID CX014
Include address on electronic claims –
DentalQuest, LLC 11100 W. Liberty Drive
Milwaukee, WI 53224

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DentaQuest of Georgia, LLC — Statement of Members Rights and Responsibilities

The mission of DentaQuest is to expand access to high-quality, compassionate healthcare services within the allocated resources. DentaQuest is committed to ensuring that all Members are treated in a manner that respects their rights and acknowledges its expectations of Member's responsibilities. The following is a statement of Member's rights and responsibilities.

1 All Members have a right to receive pertinent written and up-to-date information about DentaQuest, the managed care services DentaQuest provides, the Participating Providers and dental offices, as well as Member rights and responsibilities.

2 All Members have a right to privacy and to be treated with respect and recognition of their dignity when receiving dental care.

3 All Members have the right to fully participate with caregivers in the decision making process surrounding their health care.

4 All Members have the right to be fully informed about the appropriate or medically necessary treatment options for any condition, regardless of the coverage or cost for the care discussed.

5 All Members have the right to voice a complaint against DentaQuest, or any of its participating dental offices, or any of the care provided by these groups or people, when their performance has not met the Member's expectations.

6 All Members have the right to appeal any decisions related to patient care and treatment. Members may also request an external review or second opinion.

7 All Members have the right to make recommendations regarding DentaQuest's/Plan's members' rights and responsibilities policies.

Likewise:

1 All Members have the responsibility to provide, to the best of their abilities, accurate information that DentaQuest and its participating dentists need in order to provide the highest quality of health care services.

2 All Members have a responsibility to closely follow the treatment plans and home care instructions for the care that they have agreed upon with their health care practitioners.

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3 All Members, have the responsibility to participate in understanding their health problems and developing mutually agreed upon treatment goals to the degree possible.

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DentaQuest of Georgia, LLC Statement of Provider Rights and Responsibilities

Providers shall have the right to:

1 Communicate with patients, including Members regarding dental treatment options.

2 Recommend a course of treatment to a Member, even if the course of treatment is not a covered benefit, or approved by Plan/DentaQuest.

3 File an appeal or complaint pursuant to the procedures of Plan/DentaQuest.

4 Supply accurate, relevant, factual information to a Member in connection with an appeal or complaint filed by the Member.

5 Object to policies, procedures, or decisions made by Plan/DentaQuest.

6 If a recommended course of treatment is not covered, e.g., not approved by Plan/DentaQuest, the participating Provider must notify the Member in writing and obtain a signature of waiver if the Provider intends to charge the Member for such a non-compensable service.

7 To be informed of the status of their GA CVO credentialing or recredentialing application, upon request.

* * *

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1.00 Patient Eligibility Verification Procedures

1.01 State Eligibility System

Providers must verify the member's eligibility within 72 hours after services are rendered using the State's Eligibility System (website below). Prior to rending services, print out a copy of the member's eligibility from the State's system and keep a copy of it in the member's file. If the claim is denied due to member ineligibility, providers should submit the print out of the member's eligibility to the State's Eligibility System with a copy of the claim to DentaQuest by e-mail or standard mail:

E-mail: providerclaimappeals@dentaquest.com **Address:**
DentaQuest - Eligibility 11100 W. Liberty Drive Milwaukee, WI 53224

Georgia Department of Community Health www.mmis.georgia.gov 800.766.4456

1.02 Plan Eligibility

Any person who is enrolled in a Plan's program is eligible for benefits under the Plan certificate.

Amerigroup Community Care in Georgia: 800.454.3730 or
https://providers.amerigroup.com/GA

1.03 Member Identification Card

Members receive identification cards from their Plan. Participating Providers are responsible for verifying that Members are eligible at the time services are rendered and to determine if recipients have other health insurance.

Please note that due to possible eligibility status changes, this information does not guarantee payment and is subject to change without notice.

DentaQuest recommends that each dental office make a photocopy of the Member's identification card each time treatment is provided. It is important to note that the Health Plan identification card is not dated and it does not need to be returned to the Health Plan should a Member lose eligibility. Therefore, **an identification card in itself does not guarantee that a person is currently enrolled in the Health Plan.**

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Sample of Amerigroup Community Care I.D. Cards

[Insert Picture]

1.04 DentaQuest Eligibility System

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Participating Providers may access Member eligibility information through DentaQuest's Interactive Voice Response (IVR) system or through the "Providers Only" section of DentaQuest's website at www.dentaquest.com. The eligibility information received from either system will be the same information you would receive by calling DentaQuest's Customer Service Department; however, by utilizing either system you can get information 24 hours a day, 7 days a week without having to wait for an available Customer Service Representative.

Access to eligibility information via the Internet

DentaQuest's Internet currently allows Providers to verify a Member's eligibility as well as submit claims directly to DentaQuest. You can verify the Member's eligibility on-line by entering the Member's date of birth, the expected date of service and the Member's identification number or last name and first initial. To access the eligibility information via DentaQuest's website, simply log on to the website at www.dentaquest.com. Once you have entered the website, click on "DentaQuest" and then click on "For Providers Only." You will then be able to log in using your password and ID. First time users will have to register by utilizing their 6 digit DentaQuest Location ID, office name and office address. Please refer to your payment remittance or contact DentaQuest's Customer Service Department at 800.516.0124 to obtain your location ID. Once logged in, select "eligibility look up" and enter the applicable information for each Member you are inquiring about. You are able to check on an unlimited number of patients and can print off the summary of eligibility given by the system for your records.

Access to eligibility information via the IVR line

To access the IVR, simply call DentaQuest's Customer Service Department at 800.516.0124 and press 1 for eligibility. The IVR system will be able to answer all of your eligibility questions for as many Members as you wish to check. Once you have completed your eligibility checks, you will have the option to transfer to a Customer Service Representative during regular business hours to answer any additional questions, i.e. Member history, which you may have. Using your telephone keypad, you can request eligibility information on a Medicaid or Medicare Member by entering your 6digit DentaQuest location number, the Member's recipient identification number and an expected date of service. Specific directions for utilizing the IVR to check eligibility are listed below. After our system analyzes the information, the patient's eligibility for coverage of dental services will be verified. If the system is unable to verify the Member information you entered, you will be transferred to a Customer Service Representative during regular business hours.

Directions for using DentaQuest's IVR to verify eligibility:

Entering system with Tax and Location ID's

Call DentaQuest Customer Service at 800.516.0124.

1. After the greeting, stay on the line for English or press 1 for Spanish.
2. When prompted, press or say 2 for Eligibility.
3. When prompted, press or say 1 if you know your NPI (National Provider Identification number) and Tax ID number.
4. If you do not have this information, press or say 2. When prompted, enter your User ID (previously referred to as Location ID) and the last 4 digits of your Tax ID number.
5. Does the member's ID have **numbers and letters** in it? If so, press or say 1. When prompted, enter the member ID.
6. Does the member's ID have **only numbers** in it? If so, press or say 2. When prompted, enter the member ID.
7. Upon system verification of the Member's eligibility, you will be prompted to repeat the information given, verify the eligibility of another member, get benefit information, get limited claim history on this member, or get fax confirmation of this call.
8. If you choose to verify the eligibility of an additional Member(s), you will be asked to repeat step 5 above for each Member.

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Please note that due to possible eligibility status changes, the information provided by either system does not guarantee payment.

If you are having difficulty accessing either the IVR or website, please contact the Customer Service Department at 800.516.0124. They will be able to assist you in utilizing either system.

1.05 Health Plan Facility Authorization Phone Number

Providers should submit services to be rendered in an outpatient setting to DentaQuest for pre-authorization. DentaQuest will determine the medical necessity of the request. If approved, DentaQuest will forward the request to Plan for approval of the facility and anesthesia. Each Plan will send the approval for the facility and anesthesia, DentaQuest will return the authorization determination letter for the professional services to be rendered. All facilities must be contracted with Plan for consideration. Requests should be sent in writing to DentaQuest at:

DentaQuest of GA –O.R. Authorizations 11100 W. Liberty Drive Milwaukee, WI 53224
Fax: 262-834-3575

Or submitted on-line at www.dentaquest.com e-mail: GAIVSedationRequests@dentaquest.com

1.06 Specialist Referral Process

A patient requiring a referral to a dental specialist can be referred directly to any specialist contracted with DentaQuest without authorization from DentaQuest. The dental specialist is responsible for obtaining prior authorization for services according to Appendix B of this manual. If you are unfamiliar with the DentaQuest contracted specialty network or need assistance locating a certain specialty, please contact DentaQuest's Member Services Department at the telephone number found on page 2 of this manual.

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1.07 Member Transportation

To arrange a ride for a PeachCare for Kids™ member in any of the three regions, call Southeastrans at 1-800-657-9965.

Georgia Medicaid will provide children with a ride to and from healthcare services. Call the company that serves your area. Call at least 3 days before your appointment if you can. Here are the numbers to call:

 Atlanta: 404-209-4000 (Southeastrans) **Central:** 1-866-991-6701 (Southeastrans) **Southwest:** 1-866-443-0761 (Southwest Georgia Development)

1.08 Medical History Form

It is required that a Medical History Form be completed for each patient and maintained in the patients medical record. An example of a Medical History Form can be found on page A-20.

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2.00 Authorization for Treatment

2.01 Dental Treatment Requiring Authorization

Authorization is a utilization tool that requires Participating Providers to submit “documentation” associated with certain dental services for a Member. Participating Providers will not be paid if this “documentation” is not provided to DentaQuest. Participating Providers must hold the Member, DentaQuest, Plan and Agency harmless as set forth in the Provider Participation Agreement if coverage is denied for failure to obtain authorization (either before or after service is rendered).

DentaQuest utilizes specific dental utilization criteria as well as an authorization process to manage utilization of services. DentaQuest’s operational focus is to assure compliance with its utilization criteria. The criteria are included in this manual (see Clinical Criteria section). Please review these criteria as well as the Benefits covered to understand the decision making process used to determine payment for services rendered.

- Expedited Authorizations (Emergency treatment)

  In an **emergency** situation, the need to prior authorize services is waived. An Emergency is defined as treatment to ameliorate pain, infection, swelling, uncontrolled hemorrhage and traumatic injury that would lead a prudent layperson to reasonably expect that the absence of immediate care would result in serious impairment to the dentition or would place the person’s oral health in serious jeopardy.

  In the event a Provider determines that the fourteen (14) day standard timeframe could seriously jeopardize the Member’s life or health, DentaQuest makes an expedited authorization determination and provides notice within twenty-four (24) hours. DentaQuest may extend the twenty-four (24) hour period for up to five (5) Business Days if the Member or the Provider requests an extension, or if DentaQuest justifies to DCH a need for additional information and the extension is in the Member’s interest.

  A provider may choose to submit for authorization and payment retrospectively in emergency situations. Claims submitted for retro-review must be submitted within thirty (30) calendar days from the date of service.

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The retrospective review claim is reviewed by the Benefit Examiner to determine coverage and to certify that the services were urgent or emergent in nature. The clinical criteria utilized in the retrospective review are the same criteria utilized in the prior authorization process to determine medical necessity and appropriateness of care. A Dental Director reviews all services denied for medical necessity.

Claims should be sent on an ADA approved claim form. The tables of Covered Services (Exhibits) contain a column marked Authorization Required. A "Yes" in this column indicates that the service listed requires authorization (documentation) to be considered for reimbursement.

Your submission of "documentation" should include:

- Radiographs, narrative, or other information where requested (See Exhibits for specifics by code)
- CDT codes on the claim form
- Date of Service

It is essential that the Participating Provider understand that claims sent without this "documentation" will be denied.

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DentaQuest of Georgia, LLC

 Standard Authorizations (Non-emergency treatment)

Services that require authorization (non-emergency) should not be started prior to the determination of coverage (approval or denial of the authorization). Non-emergency treatment started prior to the determination of coverage will be performed at the financial risk of the dental office. If coverage is denied, the treating dentist will be financially responsible and may not balance bill the Member, the Plan and/or DentaQuest.

Your submission of “documentation” should include:

- Radiographs, narrative, or other information where requested (See Exhibits for specifics by code)
- CDT codes on the claim form

Your submission should be sent on an ADA approved claim form. The tables of Covered Services (Exhibits) contain a column marked Authorization Required. A “Yes” in this column indicates that the service listed requires authorization (documentation) to be considered for reimbursement.

After the DentaQuest dental director reviews the documentation, the submitting office shall be provided an authorization number within 14 days from receipt of request. An extension may be granted for an additional fourteen (14) calendar days if the member or provider requests an extension, or if DentaQuest justifies to DCH a need for additional information and the extension is in the member’s interest. The authorization number will be issued to the submitting office by mail and must be submitted with the other required claim information after the treatment is rendered.

As a reminder, providers must submit a completed authorization form and all required documentation for consideration of a previously denied authorization.

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2.02 Primary Care Offices

Primary Care Physicians (PCPs) provide comprehensive Primary Care services to Plan members. PCPs coordinate, monitor and supervise the delivery of Primary Care services to each member.

2.03 Payment for Non-Covered Services

Participating Providers shall hold Members, DentaQuest, Plan and Agency harmless for the payment of non-Covered Services except as provided in this paragraph. Provider may bill a Member for non-Covered Services if the Provider obtains a written waiver from the Member prior to rendering such service that indicates:

- The services to be provided;
- DentaQuest, Plan and Agency will not pay for or be liable for said services; and
- Member will be financially liable for such services.

2.04 Electronic Attachments

A. FastAttach™ - DentaQuest accepts dental radiographs electronically via **FastAttach™** for authorization requests. DentaQuest, in conjunction with National Electronic Attachment, LLC (NEA), allows Participating Providers the opportunity to submit all claims electronically, even those that require attachments. This program allows transmissions via secure Internet lines for radiographs, periodontic charts, intraoral pictures, narratives and EOBs.

FastAttach™ is inexpensive and easy to use, reduces administrative costs, eliminates lost or damaged attachments and accelerates claims and prior authorization processing. It is compatible with most claims clearinghouse or practice management systems.

For more information or to sign up for FastAttach go to www.nea-fast.com or call NEA at:

800.782.5150

B. OrthoCAD™ DentaQuest accepts orthodontic models electronically via **OrthoCAD™** for authorization requests. DentaQuest allows Participating Providers the opportunity to submit all orthodontic models electronically. This program allows transmissions via secure Internet lines for orthodontic models. **OrthoCAD™** is inexpensive and easy to use, reduces administrative costs, eliminates lost or damaged

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models and accelerates claims and prior authorization processing. It is compatible with most claims clearinghouse or practice management systems.

For more information or to sign up for **OrthoCAD™** go to www.orthocad.com or call **OrthoCAD™** at: 800.577.8767.

2.05 Prior Approval Process after ACS/DCH Approval

Step 1: Provider completes their ADA claim form which includes all services that will be rendered

Step 2: Attach the prior approval from ACS/DCH to the claim form

Step 3: Mail these documents to DentaQuest at:
Attn: Prior Approval - GA 11100 W. Liberty Drive Milwaukee, WI 53224

**If the office has scanning capabilities they can request this via the website by scanning in the prior approval and attaching that document to the authorization form*

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Step 4: Provider will receive a written determination letter via mail with the new authorization number that is to be used through DentaQuest. Provider can also receive the new authorization number on DentaQuest's website. Services are not going through the approval process again, instead are being transferred to DentaQuest.

If you have any offices experiencing problems with this process please refer those providers to contact Provider Engagement for assistance at 1-800-516-0124.

Please be advised that authorizations are valid for 180 days.

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3.00 Participating Hospitals

Upon approval, Participating Providers are required to administer services at Plan's participating hospitals when services are not able to be rendered in the office. Participating Hospitals may change. Please contact plan for current listing.

Amerigroup Community Care participating hospitals can also be located in the following health plan link:

http://amerigroup.prismisp.com/

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4.00 Claim Submission Procedures (claim filing options)

DentaQuest receives dental claims in four possible formats. These formats include:

 Electronic claims via DentaQuest's website (www.dentaquest.com). Electronic submission via clearinghouses. HIPAA Compliant 837D File. Paper claims.

4.01 Electronic Claim Submission Utilizing DentaQuest's Internet Website

Participating Providers may submit claims directly to DentaQuest by utilizing the "Provider's Only" section of our website. Submitting claims via the website is very quick and easy. It is especially easy if you have already accessed the site to check a Member's eligibility prior to providing the service.

To submit claims via the website, simply log on to www.dentaquest.com. Once you have entered the website, click on "DentaQuest", and then click on "For Providers Only." You will then be able to log in using your password and ID. First time users will have to register by utilizing their DentaQuest 6 digit Location ID prior to logging in. Once logged in, select "enter a claim now" and enter the Member's applicable information in the field provided. It is NOT necessary to enter the Member's last name and/or first initial; only the identification number, date of birth, and date of service are required. Next you will click on the word "before" that appears below the Member's DOB field to verify eligibility and populate the name fields automatically. Once this information is generated you may now begin to enter the claim line detail to complete the submission.

If you have questions on submitting claims or accessing the website, please contact our Systems Operations Department at 800.417.7140 or via e-mail at:

EDITeam@greatdentalplans.com

4.02 Electronic Claim Submission via Clearinghouse

DentaQuest works directly with the following vendors for claim submissions to DentaQuest. Emdeon (1-888-255-7293) Tesia 1-800-724-7240 EDI Health Group 1-800-576-6412 Secure EDI 1-877-466-9656

You can contact your software vendor and make certain that they have DentaQuest listed as the payer and claim mailing address on your electronic claim. Your software vendor will be able to provide you with

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any information you may need to ensure that submitted claims are forwarded to DentaQuest. DentaQuest's Payor ID is CX014.

4.03 HIPAA Compliant 837D File

For Providers who are unable to submit electronically via the Internet or a clearinghouse, DentaQuest will work directly with the Provider to receive their claims electronically via a HIPAA compliant 837D or 837P file from the Provider's practice management system. Please email EDITeam@greatdentalplans.com to inquire about this option for electronic claim submission.

4.04 NPI Requirements for Submission of Electronic Claims

In accordance with the HIPAA guidelines, DentaQuest has adopted the following NPI standards in order to simplify the submission of claims from all of our providers, conform to industry required standards and increase the accuracy and efficiency of claims administered by DentaQuest.

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- Providers must register for the appropriate NPI classification at the following website https://nppes.cms.hhs.gov/NPPES/Welcome.do and provide this information to DentaQuest in its entirety.
- All providers must register for an Individual NPI. You may also be required to register for a group NPI (or as part of a group) dependant upon your designation.
- When submitting claims to DentaQuest you must submit all forms of NPI properly and in their entirety for claims to be accepted and processed accurately. If you registered as part of a group, your claims must be submitted with both the Group and Individual NPI's. These numbers are not interchangeable and could cause your claims to be returned to you as non-compliant.
- If you are presently submitting claims to DentaQuest through a clearinghouse or through a direct integration you need to review your integration to assure that it is in compliance with the revised HIPAA compliant 837D format. This information can be found on the 837D Companion Guide located on the Provider Web Portal.

4.05 Paper Claim Submission

- Claims must be submitted on ADA approved claim forms or other forms approved in advance by DentaQuest.

- Member name, identification number, and date of birth must be listed on all claims submitted. If the Member identification number is missing or miscoded on the claim form, the patient cannot be identified. This could result in the claim being returned to the submitting Provider office, causing a delay in payment.

- The Provider and office location information must be clearly identified on the claim. Frequently, if only the dentist signature is used for identification, the dentist's name cannot be clearly identified. Please include either a typed dentist (practice) name or the DentaQuest Provider identification number.

- The date of service must be provided on the claim form for each service line submitted.

- The paper claim must contain an acceptable provider signature.

- Approved ADA dental codes as published in the current CDT book or as defined in this manual must be used to define all services.

- The paper claim form must contain a valid provider NPI (National Provider Identification) number. In the event of not having this box on the claim form, the NPI must still be included on the form. The ADA

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claim form only supplies 2 fields to enter NPI. On paper claims, the Type 2 NPI identifies the payee, and may be submitted in conjunction with a Type 1 NPI to identify the dentist who provided the treatment. For example, on a standard ADA Dental Claim Form, the treating dentist's NPI is entered in field 54 and the billing entity's NPI is entered in field 49.

- List all quadrants, tooth numbers and surfaces for dental codes that necessitate identification (extractions, root canals, amalgams and resin fillings). Missing tooth and surface identification codes can result in the delay or denial of claim payment.

- Affix the proper postage when mailing bulk documentation. DentaQuest does not accept postage due mail. This mail will be returned to the sender and will result in delay of payment.

Paper Claims should be mailed to the following address:

DentaQuest of GA, LLC-Claims 11100 W.
Liberty Drive

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Milwaukee, WI 53224

DentaQuest processes all claims by receipt date.

4.06 Coordination of Benefits (COB)

When DentaQuest is the secondary insurance carrier, a copy of the primary carrier's Explanation of Benefits (EOB) must be submitted with the claim. For electronic claim submissions, the payment made by the primary carrier must be indicated in the appropriate COB field. When a primary carrier's payment meets or exceeds a provider's contracted rate or fee schedule, DentaQuest will consider the claim paid in full and no further payment will be made on the claim.

4.07 Filing Limits

Georgia timely submission is 6 months from the month of service.

Timely filing for COB is 90 days from the date of denial or payment of the primary carrier's EOB.

Timely resubmission of a previously denied claim must be submitted within 6 months from the month in which the service was rendered or within 3 months of the month in which the denial occurred, which ever is later.

4.08 Receipt and Audit of Claims

In order to ensure timely, accurate remittances to each participating Provider, DentaQuest performs an audit of all claims upon receipt. This audit validates Member eligibility, procedure codes and dentist identifying information. A DentaQuest Benefit Analyst analyzes any claim conditions that would result in non-payment. When potential problems are identified, your office may be contacted and asked to assist in resolving this problem. Please contact our Customer Service Department with any questions you may have regarding claim submission or your remittance.

Each DentaQuest Provider office receives an "explanation of benefit" report with their remittance. This report includes patient information and an allowable fee by date of service for each service rendered.

4.09 Direct Deposit

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As a benefit to participating Providers, DentaQuest offers Direct Deposit for claims payments. This process improves payment turnaround times as funds are directly deposited into the Provider’s banking account.

To receive claims payments through the Direct Deposit Program, Providers must:

- Complete and sign the Direct Deposit Authorization Form found on page A-19 of this manual.
- Attach a voided check to the form. *The authorization cannot be processed without a voided check.*
- Return the Direct Deposit Authorization Form and voided check to DentaQuest.

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11100 W. Liberty Drive Milwaukee, WI 53224 ATTN: PDA Department The Direct Deposit Authorization Form must be legible to prevent delays in processing. Providers should allow up to six weeks for the Direct Deposit Program to be implemented after the receipt of completed paperwork. Providers will receive a bank note one check cycle prior to the first Direct Deposit payment.

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Providers enrolled in the Direct Deposit process must notify DentaQuest of any changes to bank accounts such as: changes in routing or account numbers, or a switch to a different bank. All changes must be submitted via the Direct Deposit Authorization Form. Changes to bank accounts or banking information typically take 2 -3 weeks. DentaQuest is not responsible for delays in funding if Providers do not properly notify DentaQuest in writing of any banking changes.

Providers enrolled in the Direct Deposit Program are required to access their remittance statements online and will no longer receive paper remittance statements. Electronic remittance statements are located on DentaQuest's Provider Web Portal (PWP). Providers may access their remittance statements by following these steps:

1. Login to the PWP at www.dentaquest.comw
2. Under the Documents header, Select **Remittance Documents**
3. Click on the **View Remittance Documents** button to display the remittance notice
4. Click on the **View** button at the right end of the specific remittance that you would like to view
5. The remittance will display on the screen.

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5.00 Health Insurance Portability and Accountability Act (HIPAA)

As a healthcare provider, your office is required to comply with all aspects of the HIPAA regulations in effect as indicated in the final publications of the various rules covered by HIPAA.

DentaQuest has implemented various operational policies and procedures to ensure that it is compliant with the Privacy, Administrative Simplification and Security Standards of HIPAA. One aspect of our compliance plan is working cooperatively with our providers to comply with the HIPAA regulations. In relation to the Privacy Standards, DentaQuest has previously modified its provider contracts to reflect the appropriate HIPAA compliance language. These contractual updates include the following in regard to record handling and HIPAA requirements:

- Maintenance of adequate dental/medical, financial and administrative records related to covered dental services rendered by Provider in accordance with federal and state law.

- Safeguarding of all information about Members according to applicable state and federal laws and regulations. All material and information, in particular information relating to Members or potential Members, which is provided to or obtained by or through a Provider, whether verbal, written, tape, or otherwise, shall be reported as confidential information to the extent confidential treatment is provided under state and feral laws.

- Neither DentaQuest nor Provider shall share confidential information with a Member's employer absent the Member's consent for such disclosure.

- Provider agrees to comply with the requirements of the Health Insurance Portability and Accountability Act ("HIPAA") relating to the exchange of information and shall cooperate with DentaQuest in its efforts to ensure compliance with the privacy regulations promulgated under HIPAA and other related privacy laws.

Provider and DentaQuest agree to conduct their respective activities in accordance with the applicable provisions of HIPAA and such implementing regulations.

In relation to the Administrative Simplification Standards, you will note that the benefit tables included in this ORM reflect the most current coding standards (CDT-4) recognized by the ADA. Effective the date of this manual, DentaQuest will require providers to submit all claims with the proper CDT-4 codes listed in this manual. In addition, all paper claims must be submitted on the current approved ADA claim form.

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Note: Copies of DentaQuest's HIPAA policies are available upon request by contacting DentaQuest's Customer Service department at 800.341.8478 or via e-mail at denelig.benefits@dentaquest.com.

5.01 HIPAA Companion Guide

To view a copy of the most recent Companion Guide please visit our website at www.dentaquest.com. Once you have entered the website, click on the "Dentist" icon. From there choose your 'State" and press go. You will then be able to log in using your password and ID. Once you have logged in, click on the link named "Related Documents' (located under the picture on the right hand side of the screen).

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6.00 Inquiries, Complaints and Grievances (Policies 200.010, 200.011, 200.017C, 200.019)

6.01 Provider Complaints and Appeals

DentaQuest adheres to Georgia DCH and Plan requirements related to processing complaints and appeals. Unless otherwise required by Agency and Plan, DentaQuest processes such inquires, complaints, and grievances consistent with the following:

A. **Informal Claim Adjustments or Claims Complaints-** Providers may submit Informal Claim Adjustments or Claim Complaints verbally (by telephone or in person) or in writing. An Informal Claim Adjustment/Claim Complaint is a verbal or written expression by a Provider which indicates dissatisfaction or dispute with DentaQuest's claim adjudication to include the amount reimbursed or regarding denial of a particular service.

B. **Administrative Complaints:** Complaints in reference to administrative functions policies and procedures of the Company and do not include claim or authorization denial issues.

C. **Claim Appeals:** Appeals in reference to a denial issued by Claims for reasons other that lack of authorization or lack of supporting medical information. Providers are offered 30 days to file written appeals in reference to claim denials. DentaQuest will process provider claim appeals within 30 days of receipt.

D. **Pre-Authorization Appeals:** Appeals in reference to a pre-authorization denial issued for a lack of required authorization or lack of supporting medical documentation. Providers may only file an appeal related to the denial of a prior authorization with the member's consent. Provider appeals with member consent shall be deemed a member appeal and handled in accordance with section 6.02.

Claim and pre-authorization appeals may be sent to DentaQuest in writing or e-mail to:

DentaQuest of GA, LLC-Appeals 11100 W. Liberty Drive Milwaukee, WI 53224
Providerclaimappeals@dentaquest.com

E. **Administrative Law Hearing** – Providers have 15 days from the date of denial to file for an Administrative Law Hearing. The Notice of Adverse Action contains the address where a Provider's request for an Administrative Law Hearing should be sent. It also notifies the Provider that a request for an Administrative Law Hearing must include the following

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information:

E.01 A clear expression by the Provider that he/she wishes to present his/her case to an Administrative Law Judge;

E.02 Identification of the Action being appealed and the issues that will be addressed at the hearing;

E.03 A specific statement of why the Provider believes the Contractor's Action is wrong; and

E.04 A statement of the relief sought.

Administrative Law Hearing requests should be sent to in writing:

Department of Community Health Legal Services Section Two Peachtree Street, NW-40th Floor

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Atlanta, Georgia 30303-3159

F. Arbitration – The Provider can select binding arbitration by a private arbitrator who is certified by a nationally recognized association that provides training and certification in alternative dispute resolution. If DentaQuest and the provider are unable to agree on an association, the rules of the American Arbitration Association shall apply. The arbitrator shall have experience and expertise in the health care field and shall be selected according to the rules of his or her certifying association. Arbitration conducted pursuant to this Code section shall be binding on the parties. The arbitrator shall conduct a hearing and issue a final ruling within 90 days of being selected, unless DentaQuest and the provider mutually agree to extend this deadline. All costs of arbitration, not including attorney's fees, shall be shared equally by the parties.

6.02 Member Administrative Reviews and Member Grievances

Administrative Reviews

An Administrative Review is a request for a change in DentaQuest's decision regarding a member's care. Examples include:

 DentaQuest's refusal to pay for something a member feels should be covered A dentist didn't provide the care a member feels they need A dentist cuts back on services a member had been receiving

Requests for Administrative Reviews may be made by a: member, provider, or a member's representative and must be requested within 30 days of receipt of the adverse decision. Requests for Administrative Reviews may be made orally by contacting the health plan or sent in writing to:

Amerigroup Community Care
Medical Administrative Reviews
P.O. Box 62429 Virginia Beach, VA
23466-2429

Peach State Health Plan
Attn: Appeals and Grievances Coordinator 1100 Circle 75 Parkway, Suite 1100 Atlanta, GA 30339

A decision is made by the CMO within 45 days from receipt of the request for an Administrative

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Review.

Administrative Law (Medicaid) and DCH (PeachCare) Hearings

Peach Care members do not have access to the Medicaid Administrative Law Hearing process. If a Peach Care member is dissatisfied with a Notice of Adverse Action issued through an Administrative Review, the member can request a review of the decision by the State Management Review Committee (level two) in writing to:

PeachCare for Kids® Two Peachtree Street, NW Atlanta, GA 30303-3159

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Medicaid members may request an Administrative Law Hearing if members are dissatisfied with the outcome of the Administrative Review process. Members must complete the Administrative Review process prior to filing a hearing request with the State and must request the hearing within 30 calendar days of receipt of the Administrative Review Decision. Only the member or member's representative may request an Administrative Law Hearing. Requests for Administrative Law Hearings may be made in writing to:

Department of Community Health Legal Services
General Counsel's Office Two Peachtree
Street, NW-40th Floor Atlanta, GA
30303-3159

Grievances

Members may submit grievances to their Health Plan telephonically or in writing on any Georgia Families program issue other than decisions that deny, delay, reduce, or terminate dental services. Some examples of complaints include: access to dental care services, provider care and treatment, or administrative issues. Member complaints should be directed to:

Amerigroup Community Care
Attn: Medical Appeals P.O. Box 62429 Virginia Beach, VA 23466-2429

Peach State Health Plan
Attn: Appeals and Grievances Coordinator 1100
Circle 75 Parkway, Suite 1100 Atlanta, GA 30339

A response to member complaints will be supplied immediately if possible but within no more than 90 calendar days from the date the grievance is received.

Note: Copies of DentaQuest policies and procedure can be requested by contacting Customer Service at 800.516.0124. (Policies 200.010, 200.011, 200.013, 200.017C, 200.019) or via e-mail at: denclaims@dentaquest.com

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7.00 Utilization Management Program (Policies 500 Series)

7.01 Introduction

Reimbursement to dentists for dental treatment rendered can come from any number of sources such as individuals, employers, insurance companies and local, state or federal government. The source of dollars varies depending on the particular program. For example, in traditional insurance, the dentist reimbursement is composed of an insurance payment and a patient coinsurance payment. In State Medical Assistance Dental Programs (Medicaid), the State Legislature annually appropriates or "budgets" the amount of dollars available for reimbursement to the dentists as well as the fees for each procedure. Since there is usually no patient co-payment, these dollars represent all the reimbursement available to the dentist. These "budgeted" dollars, being limited in nature, make the fair and appropriate distribution to the dentists of crucial importance.

7.02 Community Practice Patterns

To do this, DentaQuest has developed a philosophy of Utilization Management that recognizes the fact that there exists, as in all healthcare services, a relationship between the dentist's treatment planning, treatment costs and treatment outcomes. The dynamics of these relationships, in any region, are reflected by the "community practice patterns" of local dentists and their peers. With this in mind, DentaQuest's Utilization Management Programs are designed to ensure the fair and appropriate distribution of healthcare dollars as defined by the regionally based community practice patterns of local dentists and their peers.

All utilization management analysis, evaluations and outcomes are related to these patterns. DentaQuest's Utilization Management Programs recognize that there exists a normal individual dentist variance within these patterns among a community of dentists and accounts for such variance. Also, specialty dentists are evaluated as a separate group and not with general dentists since the types and nature of treatment may differ.

7.03 Evaluation

DentaQuest's Utilization Management Programs evaluate claims submissions in such areas as:

 Diagnostic and preventive treatment; Patient treatment planning and sequencing; Types of treatment; Treatment outcomes; and Treatment cost effectiveness.

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7.04 Results

Therefore, with the objective of ensuring the fair and appropriate distribution of these "budgeted" Medicaid Assistance Dental Program dollars to dentists, DentaQuest's Utilization Management Programs will help identify those dentists whose patterns show significant deviation from the normal practice patterns of the community of their peer dentists (typically less than 5% of all dentists). When presented with such information, dentists will implement slight modification of their diagnosis and treatment processes that bring their practices back within the normal range. However, in some isolated instances, it may be necessary to recover reimbursement.

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7.05 Fraud and Abuse (Policies 700 Series)

DentaQuest is committed to detecting, reporting and preventing potential fraud and abuse. Fraud and abuse are defined as:

Fraud: Intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under federal or state law.

Abuse: Intentional infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement, sexual abuse or sexual assault.

Provider Fraud: Provider practices that are inconsistent with sound fiscal, business or medical practices, and result in unnecessary cost to the program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care may be referred to the appropriate state regulatory agency.

Member Fraud: If a Provider suspects a member of ID fraud, drug-seeking behavior, or any other fraudulent behavior should be reported to DentaQuest.

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8.00 Quality Improvement Program (Policies 200 Series)

DentaQuest currently administers a Quality Improvement Program modeled after National Committee for Quality Assurance (NCQA) standards. The NCQA standards are adhered to as the standards apply to dental managed care. The Quality Improvement Program includes, but is not limited to:

 Provider credentialing and recredentialing. Member satisfaction surveys. Provider satisfaction surveys. Random Chart Audits. Complaint Monitoring and Trending. Peer Review Process. Utilization Management and practice patterns. Initial Site Reviews and Dental Record Reviews. Quarterly Quality Indicator tracking (i.e. complaint rate, appointment waiting time,
access to care, etc.)

A copy of DentaQuest's Quality Improvement Program is available upon request by contacting DentaQuest's Customer Service Department at 800.516.0124 or via e-mail at:

denclaims@dentaquest.com.

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9.00 Credentialing (Policies 300 Series)

DentaQuest, in conjunction with DCH and the Credentialing Verification Organization Plan, has the sole right to determine which dentists (DDS or DMD); it shall accept and continue as Participating Providers. The purpose of the credentialing plan is to provide a general guide for the acceptance, discipline and termination of Participating Providers. DentaQuest considers each Provider's potential contribution to the objective of providing effective and efficient dental services to Members of the Plan.

Note: The aforementioned policies are available upon request by contacting DentaQuest's Customer Service Department at 800.516.0124 or via e-mail at: denelig.benefits@dentaquest.com.

F

Recredentialing (Policy 300.016)
Network Providers are recredentialed at least every 36 months.

Note: The aforementioned policies are available upon request by contacting DentaQuest's Customer Service Department at 800.516.0124 or via e-mail at: denelig.benefits@dentaquest.com.

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10.00 The Patient Record

A. Organization

1. The record must have areas for documentation of the following information:

a. Registration data including a complete health history.
b. Medical alert predominantly displayed inside the chart.
c. Initial examination data.
d. Radiographs.
e. Periodontal and Occlusal status.
f. Treatment plan/Alternative treatment plan.
g. Progress notes to include diagnosis, preventive services, treatment rendered, and medical/dental consultations.
h. Miscellaneous items (correspondence, referrals, and clinical laboratory reports).

2. The design of the record must provide the capability or periodic update, without the loss of documentation of the previous status, of the following information:

a. Health history.
b. Medical alert.
c. Examination/Recall data.
d. Periodontal status.
e. Treatment plan.

1 The design of the record must ensure that all permanent components of the record are attached or secured within the record.

2 The design of the record must ensure that all components must be readily identified to the patient (i.e., patient name, and identification number on each page).

3 The organization of the record system must require that individual records be assigned to each patient.

B. Content-The patient record must contain the following:

1. Adequate documentation of registration information which requires entry of these items:

a. Patient's first and last name.

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b. Date of birth.
c. Sex.
d. Address.
e. Telephone number.
f. Name and telephone number of the person to contact in case of emergency.

2. An adequate health history that requires documentation of these items:

a. Current medical treatment.
b. Significant past illnesses.
c. Current medications.
d. Drug allergies.
e. Hematologic disorders
f. Cardiovascular disorders.
g. Respiratory disorders.
h. Endocrine disorders.
i. Communicable diseases.
j. Neurologic disorders.
k. Signature and date by patient.
l. Signature and date by reviewing dentist.
m. History of alcohol and/or tobacco usage including smokeless tobacco.

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3. An adequate update of health history at subsequent recall examinations which requires documentation of these items:

a. Significant changes in health status.
b. Current medical treatment.
c. Current medications.
d. Dental problems/concerns.
e. Signature and date by reviewing dentist.

4. A conspicuously placed medical alert inside the chart that documents highly significant terms from health history. These items are:

a. Health problems which contraindicate certain types of dental treatment.
b. Health problems that require precautions or pre-medication prior to dental treatment.
c. Current medications that may contraindicate the use of certain types of drugs or dental treatment.
d. Drug sensitivities.
e. Infectious diseases that may endanger personnel or other patients.

5. Adequate documentation of the initial clinical examination which is dated and requires descriptions of findings in these items:

a. Blood pressure. (Recommended)
b. Head/neck examination.
c. Soft tissue examination.
d. Periodontal assessment.
e. Occlusal classification.
f. Dentition charting.

6. Adequate documentation of the patient's status at subsequent Periodic/Recall examinations which is dated and requires descriptions of changes/new findings in these items:

a. Blood pressure. (Recommended)
b. Head/neck examination.
c. Soft tissue examination.
d. Periodontal assessment.
e. Dentition charting.

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7. Radiographs which are:

a. Identified by patient name.
b. Dated.
c. Designated by patient’s left and right side.
d. Mounted (if intraoral films).

8. An indication of the patient’s clinical problems/diagnosis.
9. Adequate documentation of the treatment plan (including any alternate treatment options) that specifically describes all the services planned for the patient by entry of these items:
a. Procedure.
b. Localization (area of mouth, tooth number, surface).
10. An Adequate documentation of the periodontal status, if necessary, which is dated and requires charting of the location and severity of these items:
a. Periodontal pocket depth.
b. Furcation involvement.
c. Mobility.
d. Recession.
e. Adequacy of attached gingiva.
f. Missing teeth.
11. An adequate documentation of the patient’s oral hygiene status and preventive efforts which requires entry of these items:
a. Gingival status.
b. Amount of plaque.
c. Amount of calculus.
d. Education provided to the patient.
e. Patient receptiveness/compliance.
f. Recall interval.
g. Date.
12. An adequate documentation of medical and dental consultations within and outside the practice which requires entry of these items:
a. Provider to whom consultation is directed.
b. Information/services requested.
c. Consultant’s response.
13. Adequate documentation of treatment rendered which requires entry of these items:
a. Date of service/procedure.
b. Description of service, procedure and observation. Documentation in treatment record must contain

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documentation to support the level of American Dental Association Current Dental Terminology code billed as detailed in the nomenclature and descriptors. Documentation must be written on a tooth by tooth basis for a per tooth code, on a quadrant basis for a quadrant code and on a per arch basis for an arch code.

c. Type and dosage of anesthetics and medications given or prescribed.

d. Localization of procedure/observation. (tooth #, quadrant etc.)

e. Signature of the Provider who rendered the service.

14. Adequate documentation of the specialty care performed by another dentist that includes:

a. Patient examination.

b. Treatment plan.

c. Treatment status.

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C. Compliance

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1 The patient record has one explicitly defined format that is currently in use.
2 There is consistent use of each component of the patient record by all staff.
3 The components of the record that are required for complete documentation of each patient's status and care are present.
4 Entries in the records are legible.
5 Entries of symbols and abbreviations in the records are uniform, easily interpreted and are commonly understood in the practice.

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11.00 Patient Recall System Requirements

A. Recall System Requirement

Each participating DentaQuest office is required to maintain and document a formal system for patient recall. The system can utilize either written or phone contact. Any system should encompass routine patient check-ups, cleaning appointments, follow-up treatment appointments, and missed appointments for any Health Plan enrollee that has sought dental treatment.

If a written process is utilized, the following language is suggested for missed appointments:

- “We missed you when you did not come for your dental appointment on month/date. Regular check-ups are needed to keep your teeth healthy.”
- “Please call to reschedule another appointment. Call us ahead of time if you cannot keep the appointment. Missed appointments are very costly to us. Thank you for your help.”

Dental offices indicate that Medicaid patients sometimes fail to show up for appointments. DentaQuest offers the following suggestions to decrease the “no show” rate. Please note Medicaid beneficiaries should not be charged for missed appointments.

- Contact the Member by phone or postcard prior to the appointment to remind the individual of the time and place of the appointment.
- If the appointment is made through a government supported screening program, contact staff from these programs to ensure that scheduled appointments are kept.

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12.00 Radiology Requirements

Accordingly, DentaQuest will be implementing a process for radiograph scanning which will improve timeliness in the claim review and decision process. To ensure proper scanning, effective May 21, 2012 **we will require radiographs be mounted when there are 5 or more radiographs submitted at one time.** Effective May 21, 2012, if 5 or more radiographs are submitted and not mounted, they will be returned to you and your request for prior authorization and/or claim will not be processed.

Acceptable methods of mounted radiographs are: Radiographs duplicated and displayed in proper order on a piece of duplicating film. Radiographs mounted in a radiograph holder or mount designed for this purpose.

Unacceptable methods of mounted radiographs are: Cut out radiographs taped or stapled together. Cut out radiographs placed in a coin envelope. Multiple radiographs placed in the same slot of a radiograph holder or mount.

Effective May 21, 2012, you will have the following options for submitting radiographs to us:

 Electronic submission using the new web portal. Electronic submission using National Electronic Attachment (NEA). For more information, please visit www.nea-fast.com and click the "Learn More" button. Submission of duplicate radiographs (which we will recycle and not return) Submission of original radiographs with a self addressed stamped envelope (SASE) so that we may return the original radiographs. Note that determinations will be sent separately and any radiographs received without a SASE will not be returned to the sender.

All radiographs should include member's name, identification number and office name to ensure proper handling.

Note: Please refer to benefit tables for radiograph benefit limitations.

DentaQuest utilizes the guidelines published by the Department of Health and Human Services, Center for Devices and Radiological Health. These guidelines were developed in conjunction with the Food and Drug Administration.

A. Radiographic Examination of the New Patient

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1. Child – primary dentition The Panel recommends posterior bitewing radiographs for a new patient, with a primary dentition and closed proximal contacts.

2. Child – transitional dentition The Panel recommends an individualized periapical/occlusal examination with posterior bitewings OR a panoramic radiograph and posterior bitewings, for a new patient with a transitional dentition.

3. Adolescent – permanent dentition prior to the eruption of the third molars

4. Adult – dentulous The Panel recommends an individualized radiographic examination consisting of selected periapicals with posterior bitewings for a new dentulous adult patient.

5. Adult – edentulous

The Panel recommends an individualized radiographic examination consisting of selected periapicals with posterior bitewings for a new adolescent patient.

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The Panel recommends a full-mouth intraoral radiographic survey OR a panoramic radiograph for the new edentulous adult patient.

B. Radiographic Examination of the Recall Patient

1. Patients with clinical caries or other high – risk factors for caries

a. Child – primary and transitional dentition

The Panel recommends that posterior bitewings be performed at a 6-12 month interval for those children with clinical caries or who are at increased risk for the development of caries in either the primary or transitional dentition.

b. Adolescent

The Panel recommends that posterior bitewings be performed at a 6-12 month interval for adolescents with clinical caries or who are at increased risk for the development of caries.

c. Adult – dentulous

The Panel recommends that posterior bitewings be performed at a 6-12 month interval for adults with clinical caries or who are at increased risk for the development of caries.

d. Adult – edentulous

The Panel found that an examination for occult disease in this group cannot be justified on the basis of prevalence, morbidity, mortality, radiation dose and cost. Therefore, the Panel recommends that no radiographs be performed for edentulous recall patients without clinical signs or symptoms.

2. Patients with no clinical caries and no other high risk factors for caries

a. Child – primary dentition

The Panel recommends that posterior bitewings be performed at an interval of 12-24 months for children with a primary dentition with closed posterior contacts that show no

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clinical caries and are not at increased risk for the development of caries.

b. Adolescent

The Panel recommends that posterior bitewings be performed at intervals of 12-24 months for patients with a transitional dentition who show no clinical caries and are not at an increased risk for the development of caries.

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c. Adult – dentulous

The Panel recommends that posterior bitewings be performed at intervals of 24-36 months for dentulous adult patients who show no clinical caries and are not at an increased risk for the development of caries.

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3. Patients with periodontal disease, or a history of periodontal treatment for child – primary and transitional dentition, adolescent and dentulous adult The Panel recommends an individualized radiographic survey consisting of selected periapicals and/or bitewing radiographs of areas with clinical evidence or a history of periodontal disease, (except nonspecific gingivitis).

4. Growth and Development Assessment

a. Child – Primary Dentition

The panel recommends that prior to the eruption of the first permanent tooth, no radiographs be performed to assess growth and development at recall visits in the absence of clinical signs or symptoms.

b. Child – Transitional Dentition

The Panel recommends an individualized Periapical/Occlusal series OR a Panoramic Radiograph to assess growth and development at the first recall visit for a child after the eruption of the first permanent tooth.

c. Adolescent

The Panel recommends that for the adolescent (age 16-19 years of age) recall patient, a single set of Periapicals of the wisdom teeth OR a panoramic radiograph.

d. Adult

The Panel recommends that no radiographs be performed on adults to assess growth and development in the absence of clinical signs or symptoms.

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13.00 Health Guidelines – Ages 0-18 Years NOTE: Please refer to benefit tables for benefits and limitations.

Recommendations for Preventive Pediatric Dental Care (AAPD Reference Manual 2002-2003) Periodicity and Anticipatory Guidance Recommendations (AAPD/ADA/AAP guidelines)

14.00 Clinical Criteria

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The criteria outlined in DentaQuest's Provider Office Reference Manual are based around procedure codes as defined in the American Dental Association's Code Manuals. Documentation requests for information regarding treatment using these codes are determined by generally accepted dental standards for authorization, such as radiographs, periodontal charting, treatment plans, or descriptive narratives. In some instances, the State legislature will define the requirements for dental procedures.

\These criteria were formulated from information gathered from practicing dentists, dental schools, ADA clinical articles and guidelines, insurance companies, as well as other dental related organizations. These criteria and policies must meet and satisfy specific State and Health Plan requirements as well. They are designed as *guidelines* for authorization and payment decisions and *are not intended to be all-inclusive or absolute*. Additional narrative information is appreciated when there may be a special situation.

We hope that the enclosed criteria will provide a better understanding of the decision-making process for reviews. We also recognize that "local community standards of care" may vary from region to region and will continue our goal of incorporating generally accepted criteria that will be consistent with both the concept of local community standards and the current ADA concept of national community standards. Your feedback and input regarding the constant evolution of these criteria is both essential and welcome. DentaQuest shares your commitment and belief to provide quality care to Members and we appreciate your participation in the program.

Please remember these are generalized criteria. Services described may not be covered in your particular program. In addition, there may be additional program specific criteria regarding treatment. Therefore it is essential you review the Benefits Covered Section before providing any treatment.

These clinical criteria will be used for making medical necessity determinations for prior authorizations, post payment review and retrospective review. Failure to submit the required documentation may result in a disallowed request and/or a denied payment of a claim related to that request. Some services require prior authorization and some services require pre-payment review, this is detailed in the Benefits Covered Section(s) in the "Review Required" column.

For all procedures, every Provider in the DentaQuest program is subject to random chart audits. Providers are required to comply with any request for records. These audits may occur in the Provider's office as well as in the office of DentaQuest. The Provider will be notified in writing of the results and findings of the audit.

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DentaQuest providers are required to maintain comprehensive treatment records that meet professional standards for risk management.   Please refer to the “Patient Record” section for additional detail.

Documentation in the treatment record must justify the need for the procedure performed due to medical necessity, for all procedures rendered. Appropriate diagnostic pre-operative radiographs clearly showing the adjacent and opposing teeth and substantiating any pathology or caries present are required. Post-operative radiographs are required for endodontic procedures and permanent crown placement to confirm quality of care. In the event that radiographs are not available or cannot be obtained, diagnostic quality intraoral photographs must substantiate the need for procedures rendered.

Multistage procedures are reported and may be reimbursed upon completion. The completion date is the date of insertion for removable prosthetic appliances. The completion date for immediate dentures is the date that the remaining teeth are removed and the denture is inserted. The completion date for fixed partial dentures and crowns, onlays, and inlays is the cementation date regardless of the type of cement utilized. The completion date for endodontic treatment is the date the canals are permanently filled.

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Failure to provide the required documentation, adverse audit findings, or the failure to maintain acceptable practice standards may result in sanctions including, but not limited to, recoupment of benefits on paid claims, follow-up audits, or removal of the Provider from the DentaQuest Provider Panel.

14.01 Criteria for Dental Extractions

Not all procedures require authorization.

Documentation needed for authorization procedure:

- Appropriate radiographs clearly showing the adjacent and opposing teeth should be submitted for authorization review: bitewings, periapicals or panorex.

- Treatment rendered under emergency conditions, when authorization is not possible, requires that appropriate radiographs clearly showing the adjacent and opposing teeth be submitted with the claim for review for payment.

- Narrative demonstrating medical necessity.

Criteria

The prophylactic removal of asymptomatic teeth (i.e. third molars) or teeth exhibiting no overt clinical pathology (for orthodontics) may be covered subject to consultant review.

- The removal of primary teeth whose exfoliation is imminent does not meet criteria.

- Alveoloplasty (code D7310) in conjunction with three or more extractions in the same quadrant will be covered subject to consultant review.

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Criteria for Extractions

1 The prophylactic removal of asymptomatic teeth or teeth exhibiting no overt clinical pathology is not a covered benefit.
2 The removal of primary teeth whose exfoliation is imminent is not a covered benefit.
3 In most cases, extractions that render a patient edentulous must be deferred until authorization to construct a denture has been given.
4 Alveoloplasty (code D7310) in conjunction with a surgical extraction in the same quadrant is not a covered benefit.
5 Extractions performed as part of a course of orthodontics are covered only if the orthodontic case is a covered benefit.

Authorization for Extraction of Impacted Third Molars

1 Benefit review decisions for authorization of the extraction of impacted third molar teeth will be based upon medical necessity and upon appropriate code utilization for the current ADA codes D7220, D7230, and D7240.
2 The prophylactic removal of disease-free third molars is not a covered benefit.
3 Impacted third molars that do not show radiographic evidence of complete root formation will not qualify for an authorization for extraction.
4 Impacted third molars that do not demonstrate radiographic aberrant tooth position beyond normal variations will not qualify for an authorization for extraction.
5 Impacted third molars that do not show pathology will not qualify for an authorization for extraction.
6 Normal eruption discomfort and localized inflammatory conditions will not qualify impactions for an authorization for extraction.
7 Lack of eruptive space will not qualify for an authorization for extractions of impacted third molars.

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14.02 Criteria for Cast Crowns Documentation needed for authorization of procedure:

- Appropriate radiographs clearly showing the adjacent and opposing teeth should be submitted for authorization review: bitewings, periapicals or panorex.

- Treatment rendered without necessary authorization will still require that sufficient and appropriate radiographs clearly showing the adjacent and opposing teeth be submitted with the claim for review for payment.

Criteria

- In general, criteria for crowns will be met only for permanent teeth needing multi-surface restorations where other restorative materials have a poor prognosis. Permanent molar teeth must have pathologic destruction to the tooth by caries or trauma, and should involve four or more surfaces and two or more cusps. Permanent bicuspid teeth must have pathologic destruction to the tooth by caries or trauma, and should involve three or more surfaces and at least one cusp.

- Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma, and must involve four or more surfaces and at least 50% of the incisal edge.

A request for a crown following root canal therapy must meet the following criteria: Request should include a dated post-endodontic radiograph. Tooth should be filled sufficiently close to the radiological apex to ensure that an

apical seal is achieved, unless there is a curvature or calcification of the canal that limits the ability to fill the canal to the apex. The filling must be properly condensed/obturated. Filling material does not

extend excessively beyond the apex. To meet criteria, a crown must be opposed by a tooth or denture in the opposite arch or be an abutment for a partial denture.

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 The patient must be free from active and advanced periodontal disease. The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent

teeth. Cast Crowns on permanent teeth are expected to last, at a minimum, five years. Authorizations for Crowns will not meet criteria if: A lesser means of restoration is possible. Tooth has subosseous and/or furcation caries. Tooth has advanced periodontal disease.

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 Tooth is a primary tooth. Crowns are being planned to alter vertical dimension.

14.03 Criteria for Endodontics

Not all procedures require authorization.

Documentation needed for authorization of procedure:

 Sufficient and appropriate radiographs clearly showing the adjacent and opposing teeth and a pre-operative radiograph of the tooth to be treated; bitewings, periapicals or panorex. A dated post-operative radiograph must be submitted for review for payment.

 Treatment rendered under emergency conditions, when authorization is not possible, will still require that appropriate radiographs clearly showing the adjacent and opposing teeth, pre-operative radiograph and dated post-operative radiograph of the tooth treated with the claim for retrospective review for payment. In cases where pathology is not apparent, a written narrative justifying treatment is required.

Criteria

Root canal therapy is performed in order to maintain teeth that have been damaged through trauma or carious exposure. Root canal therapy must meet the following criteria:

 Fill should be sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the dentist's ability to fill the canal to the apex.

 Fill must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.

Authorizations for Root Canal therapy will not meet criteria if:

 Gross periapical or periodontal pathosis is demonstrated radiographically (caries subcrestal or to the furcation, deeming the tooth non-restorable).

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- The general oral condition does not justify root canal therapy due to loss of arch integrity.
- Root canal therapy is for third molars, unless they are an abutment for a partial denture.
- Tooth does not demonstrate 50% bone support.
- Root canal therapy is in anticipation of placement of an overdenture.
- A filling material not accepted by the Federal Food and Drug Administration (e.g. Sargenti filling material) is used.

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Other Considerations

- Root canal therapy for permanent teeth includes diagnosis, extirpation of the pulp, shaping and enlarging the canals, temporary fillings, filling and obliteration of root canal(s), and progress radiographs, including a root canal fill radiograph.

- In cases where the root canal filling does not meet DentaQuest's treatment standards, DentaQuest can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after DentaQuest reviews the circumstances.

14.04 Criteria for Stainless Steel Crowns

Although authorization for Stainless Steel Crowns is not required, documentation justifying the need for treatment using Stainless Steel Crowns must be made available upon request for review by DentaQuest pre-operatively or post-operatively and include the following:

- Appropriate diagnostic radiographs clearly showing the adjacent and opposing teeth and pathology or caries-detecting intra-oral photographs if radiographs could not be made.

- Copy of patient's dental record with complete caries charting and dental anomalies

- Copy of detailed treatment plan.

Note: Failure to submit the required documentation if requested may result in the recoupment of benefits on a paid claim.

Criteria

- In general, criteria for stainless steel crowns will be met only for teeth needing multi-surface restorations or where amalgams, composites, and other restorative materials have a poor prognosis.

- Permanent molar teeth should have pathologic destruction to the tooth by caries or trauma, and should involve four or more surfaces and/or two or more cusps.

- Permanent bicuspid teeth should have pathologic destruction to the tooth by caries or trauma, and should involve three or more surfaces and at least one cusp.

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- Permanent anterior teeth should have pathologic destruction to the tooth by caries or trauma, and should involve four or more surfaces and at least 50% of the incisal edge.
- Primary anterior teeth should have pathologic destruction to the tooth by caries or trauma and should involve two or more surfaces or incisal decay resulting in an enamel shell.
- Primary molars should have pathologic destruction to the tooth by caries or trauma, and should involve two or more surfaces or substantial occlusal decay resulting in an enamel shell.

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 Primary teeth that have had a pulpotomy or pulpectomy performed.

Note: DentaQuest may require a second opinion for requests of more than 4 stainlesssteel crowns per patient.

An authorization for a crown on a permanent tooth following root canal therapy must meet the following criteria: Claim should include a dated post-endodontic radiograph.

 Tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the dentist's ability to fill the canal to the apex.

 The filling must be properly condensed/obturated. Filling material does not

extend excessively beyond the apex. To meet criteria, a crown must be opposed by a tooth or denture in the opposite arch or be an abutment for a partial denture.

 The patient must be free from active and advanced periodontal disease. The permanent tooth must be at least 50% supported in bone. Stainless steel crowns on permanent teeth are expected to last five years. Criteria for treatment using stainless steel crowns will not be met if: A lesser means of restoration is possible. Tooth has subosseous and/or furcation caries. Tooth has advanced periodontal disease. Member is age 6 or older and tooth is a primary tooth with exfoliation imminent. Crowns are being planned to alter vertical dimension. Tooth has no apparent pathologic destruction due to caries or trauma.

14.05 Criteria for Authorization of Operating Room (OR) Cases or Special Procedure Units (SPU)

All Operating Room (OR) Cases or (SPU) Must Have Prior Authorization (Except In Emergencies).

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Providers must submit the following documents for review by DentaQuest for authorization of OR cases:

- Copy of the patient's dental record including health history, charting of the teeth and existing oral conditions.

- Diagnostic �iagnostic patient's dental record including health hi���

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- Copy of treatment plan. A completed ADA claim form submitted for an authorization may serve as a treatment plan.

- A completed Hospital IV/Sedation Member Referral Evaluation Tool (located in Appendix A; A-8).

- Narrative describing medical necessity for OR.

- Date of Service.

- Location of Service.

Note: Failure to submit the required documentation may result in a denied request and denied payment of a claim related to that request.

† On occasion, due to the lack of physical or emotional maturity, or a disability, a patient may not cooperate enough for radiographs or intra-oral photographs to be made. If this occurs, it must be noted in the patient record and narrative describing medical necessity. Dentists who "routinely" fail to submit radiographs or intra-oral photographs may be denied authorization for treatment.

Extensive treatment plans including endodontics, implants, prosthodontics, or multiple crowns may require a second opinion as determined by DentaQuest.

The provider is responsible for choosing facilities/providers from Member's MCO panel, obtaining all necessary authorizations, and obtaining a medical history and physical examination by the patient's primary care provider. DentaQuest would not recommend that providers submit this documentation with the authorization request but would assume that this information would be documented in the patient record.

Criteria

In most situations, OR cases will be authorized for covered procedures if the following is (are) involved:

- Young children requiring extensive operative procedures such as multiple restorations, treatment of multiple abscesses, and/or oral surgical procedures if authorization documentation indicates that in-office treatment (nitrous oxide,oral, IM, or IV sedation) is not appropriate and hospitalization is not solely based upon reducing, avoiding or controlling apprehension, or upon Provider or Member convenience.

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- Patients requiring <u>extensive</u> dental procedures and classified as American Society of Anesthesiologists (ASA) class III and ASA class IV (Class III – patients with uncontrolled disease or significant systemic disease; for recent MI, recent stroke, new chest pain, etc. Class IV – patient with severe systemic disease that is a constant threat to life).*

- Medically compromised patients whose medical history indicates that the monitoring of vital signs, or the availability of resuscitative equipment is necessary during <u>extensive</u> dental procedures.*

- Patients requiring <u>extensive</u> dental procedures with a medical history of uncontrolled bleeding, severe cerebral palsy, or other medical condition that renders in-office treatment medically appropriate.*

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- Patients requiring extensive dental procedures who have documentation of psychosomatic disorders that require special treatment.*

- Cognitively disabled individuals requiring extensive dental procedures whose prior history indicates hospitalization is appropriate.*

*** The medical condition should be verified by a PCP narrative, which is submitted with the authorization request.**

14.06 Criteria for Removable Prosthodontics (Full and Partial Dentures)

Documentation needed for authorization of procedure:

- Treatment plan.

- Appropriate radiographs clearly showing the adjacent and opposing teeth must be submitted for authorization review: bitewings, periapicals or panorex.

- Treatment rendered without necessary authorization will still require appropriate radiographs clearly showing the adjacent and opposing teeth be submitted with the claim for review for payment.

- Fabrication of a removable prosthetic includes multiple steps(appointments) these multiple steps (impressions, try-in appointments, delivery etc.) are inclusive in the fee for the removable prosthetic and as such not eligible for additional compensation.

Criteria

Prosthetic services are intended to restore oral form and function due to premature loss of permanent teeth that would result in significant occlusal dysfunction.

- A denture is determined to be an initial placement if the patient has never worn a prosthesis. This does not refer to just the time a patient has been receiving treatment from a certain Provider.

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- Partial dentures are covered only for recipients with good oral health and hygiene, good periodontal health (AAP Type I or II), and a favorable prognosis where continuous deterioration is not expected.

- Radiographs must show no untreated cavities or active periodontal disease in the abutment teeth, and abutments must be at least 50% supported in bone.

- As part of any removable prosthetic service, dentists are expected to instruct the patient in the proper care of the prosthesis.

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- In general, if there is a pre-existing removable prosthesis (includes partial and full dentures), it must be at least 5 years old and unserviceable to qualify for replacement.

- The replacement teeth should be anatomically full sized teeth.

Authorizations for Removable prosthesis will not meet criteria:

- If there is a pre-existing prosthesis which is not at least 5 years old and unserviceable.

- If good oral health and hygiene, good periodontal health, and a favorable prognosis are not present.

- If there are untreated cavities or active periodontal disease in the abutment teeth.

- If abutment teeth are less than 50% supported in bone.

- If the recipient cannot accommodate and properly maintain the prosthesis (i.e.. Gag reflex, potential for swallowing the prosthesis, severely handicapped).

- If the recipient has a history or an inability to wear a prosthesis due to psychological or physiological reasons.

- If a partial denture, less than five years old, is converted to a temporary or permanent complete denture.

- If extensive repairs are performed on marginally functional partial dentures, or when a new partial denture would be better for the health of the recipient. However, adding teeth and/or a clasp to a partial denture is a covered benefit if the addition makes the denture functional.

Criteria

- If there is a pre-existing prosthesis, it must be at least 5 years old and unserviceable

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to qualify for replacement. Adjustments, repairs and relines are included with the denture fee within the first 6 months after insertion. After that time has elapsed: Adjustments will be reimbursed at one per calendar year per denture. Repairs will be reimbursed at two repairs per denture per year, with five total denture repairs per 5 years. Relines will be reimbursed once per denture every 36 months.

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- A new prosthesis will not be reimbursed for within 24 months of reline or repair of the existing prosthesis unless adequate documentation has been presented that all procedures to render the denture serviceable have been exhausted.

- Replacement of lost, stolen, or broken dentures less than 5 years of age usually will not meet criteria for pre-authorization of a new denture.

- The use of Preformed Dentures with teeth already mounted (that is, teeth set in acrylic before the initial impression) cannot be used for the fabrication of a new denture.

- All prosthetic appliances shall be inserted in the mouth and adjusted before a claim is submitted for payment.

- When billing for partial and complete dentures, dentists must list the date that the dentures or partials were inserted as the date of service. Recipients must be eligible on that date in order for the denture service to be covered.

14.07 Criteria for the Excision of Bone Tissue

To ensure the proper seating of a removable prosthetic (partial or full denture) some treatment plans may require the removal of excess bone tissue prior to the fabrication of the prosthesis. Clinical guidelines have been formulated for the dental consultant to ensure that the removal of tori (mandibular and palatal) is an appropriate course of treatment prior to prosthetic treatment.

Code D7471 (CDT–5) is related to the removal of the lateral exostosis. This code is subject to authorization and may be reimbursed for when submitted in conjunction with a treatment plan that includes removable prosthetics. These determinations will be made by the appropriate dental specialist/consultant.

Documentation needed for authorization of procedure:

- Appropriate radiographs and/or intraoral photographs/bone scans which clearly identify the lateral exostosis must be submitted for authorization review; bitewings, periapicals or panorex.

- Treatment plan – includes prosthetic plan.

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- Narrative of medical necessity, if appropriate.

- Study model or photo clearly identifying the lateral exostosis (es) to be removed.

14.08 Criteria for the Determination of a Non-Restorable Tooth

In the application of clinical criteria for benefit determination, dental consultants must consider the overall dental health. A tooth that is determined to be non-restorable may be subject to an alternative treatment plan.

A tooth may be deemed non-restorable if one or more of the following criteria are present:

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 The tooth presents with greater than a 75% loss of the clinical crown. The tooth has less than 50% bone support. The tooth has subosseous and/or furcation caries. The tooth is a primary tooth with exfoliation imminent. The tooth apex is surrounded by severe pathologic destruction of the bone. The overall dental condition (i.e. periodontal) of the patient is such that an

alternative treatment plan would be better suited to meet the patient's needs.

14.09 Criteria for General Anesthesia and Intravenous (IV) Sedation

Documentation needed for authorization of procedure:

 Treatment plan (authorized if necessary).

 Narrative describing medical necessity for General Anesthesia or IV Sedation.
 Treatment rendered under emergency conditions, when authorization is not possible, will still require submission of treatment plan and narrative of medical necessity with the claim for review for payment.

Criteria

Requests for general anesthesia or IV sedation will be authorized (for procedures covered by Health Plan) if any of the following criteria are met: Extensive or complex oral surgical procedures such as: Impacted wisdom teeth. Surgical root recovery from maxillary antrum. Surgical exposure of impacted or unerupted cuspids. Radical excision of lesions in excess of 1.25 cm. And/or one of the following medical conditions: Medical condition(s) which require monitoring (e.g. cardiac problems, severe hypertension).

 Underlying hazardous medical condition (cerebral palsy, epilepsy, mental retardation, including Down's syndrome) which would render patient noncompliant.

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- Documented failed sedation or a condition where severe periapical infection would render local anesthesia ineffective.
  - Patients 3 years old and younger with extensive procedures to be accomplished.

14.10 Criteria for Periodontal Treatment

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Not all procedures require authorization. Documentation needed for authorization of procedure:

- Radiographs – periapicals or bitewings preferred.

- Complete periodontal charting with AAP Case Type.

- Treatment plan.

Periodontal scaling and root planing, per quadrant involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. It is indicated for patients with periodontal disease and is therapeutic, not prophylactic in nature. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and as a part of pre-surgical procedures in others.

It is anticipated that this procedure would be requested in cases of severe periodontal conditions (i.e. late Type II, III, IV periodontitis) where definitive comprehensive root planing requiring local/regional block anesthesia and several appointments would be indicated.

From the American Academy of Periodontology (AAP) Policy on Scaling and Root Planing:

"Periodontal scaling is a treatment procedure involving instrumentation of the crown and root surfaces of the teeth to remove plaque, calculus, and stains from these surfaces. It is performed on patients with periodontal disease and is therapeutic, not prophylactic, in nature. Periodontal scaling may precede root planing, which is the definitive, meticulous treatment procedure to remove cementum and/or dentin that is rough and may be permeated by calculus, or contaminated with toxins or microorganisms. Periodontal scaling and root planing are arduous and time consuming. They may need to be repeated and may require local anesthetic."

Criteria

- A minimum of four (4) teeth affected in the quadrant.

- Periodontal charting indicating abnormal pocket depths in multiple sites.

- Additionally at least one of the following must be present:

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1) Radiographic evidence of root surface calculus. 2) Radiographic evidence of noticeable loss of bone support.

14.11 Criteria for Medical Immobilization* Including Papoose Boards

Written informed consent from a legal guardian must be obtained and documented in the patient record prior to medical immobilization.

The patient's record should include:

 informed consent; type of immobilization used; indication for immobilization;

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 the duration of application.

Indications*:

 patient who requires immediate diagnosis and/ or <u>limited</u> treatment and cannot cooperate due to lack of maturity; patient who requires immediate diagnosis and/ or <u>limited</u> treatment and cannot cooperate due to a mental or physical disability; when the safety of the patient and/ or practitioner would be at risk without the protective use of immobilization.

Contraindications*:

 cooperative patient; patient who cannot be immobilized safely due to associated medical conditions.

Goals of Behavior Management*:

 establish communication; alleviate fear and anxiety; deliver quality dental care; build a trusting relationship between dentist and child; and, promote the child's positive attitude towards oral/ dental health.

1 **<u>Routine</u> use of restraining devices to immobilize young children in order to complete their dental care is not acceptable practice, violates the standard of care, and will result in termination of the provider from the network.**

2 **Dentists should not restrain children without formal training at a dental school orapproved residency program.**

3 **Dentists should consider referring to specialists those patients who they consider to be candidates for immobilization.**

4 **Dental auxiliaries should not use restraining devices to immobilize children.**

*American Academy of Pediatric Dentistry. Guideline on behavior management. Reference Manual 2002-2003.

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Dental Advisory Committee Goals and Objectives

The DentaQuest of Georgia, LLC (DentaQuest) Georgia Dental Advisory Committee will work to cultivate better understanding between the dentists of the Georgia Medicaid Program and DentaQuest. The Committee shall be aware of DentaQuest's goals and limitations and utilize them to improve the partnership between the oral health community, the provider network, and DentaQuest. The goal of this partnership is to evaluate, improve and deliver the best possible oral healthcare to the Medicaid/PeachCare recipients in Georgia.

The Objectives of the Committee are:

- Advise when possible in the areas of policy development
- Help administer cost effective quality of care, by better understanding the processes used
- Work as liaisons with the provider network in order to foster cooperation with providers, such that a high standard of quality care for dental recipients in GA may be maintained.
- Set goals which are achievable based on the current economic status.
- Advise DentaQuest of areas of dental needs or concerns that may arise.
- Evaluate provider concerns that are gathered by the Care Maintenance Organizations questionnaires. Work as a group toward helping alleviate said concerns and problems.
- Achieve a better understanding of the process of Fraud and Abuse as it is reviewed in GA.
- Other projects as deemed appropriate by DentaQuest and/or the committee

Committee Composition:

Committee consists of DentaQuest staff members, a representative of the Georgia Dental Association and the Georgia Dental Society, and dentists contracted who participate in the Georgia Medicaid Program. Committee members are not held to term limitations and are able to participate for the duration of their choice. This is a voluntary program and committee members are not compensated for their participation.

16.00 Dental Home

The Dental Home is the ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. For both the Georgia Families Medicaid and the Amerigroup Georgia Families 360° programs, Dental Homes will be built from coordinated efforts of you the provider, the Amerigroup Care Coordination Team, and DentaQuest. Together we will establish a relationship with each member to ensure they are receiving proper oral healthcare

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and attending regular dental visits.

Oral health is integral to the healthy physical, social-emotional and intellectual development of every child and adult. For the special populations in the Georgia Families 360 dental program (Foster Care, Adoption Assistance, and the Department of Juvenile Justice), building a strong oral health foundation is all the more critical. Individuals in a Dental Home are more likely to receive appropriate and routine oral health care, thereby reducing the risk of preventable dental/oral disease. By establishing Dental Homes for this membership, we are providing a key component to each child's health.

"Dental Home Rosters" are refreshed daily and can be found on the provider web portal. The roster will contain a detailed listing of every member who has chosen them as their PCD. Providers who have any questions on assignments are encouraged to call the DentaQuest Provider Services Call Center or contact the Amerigroup Care Coordination Team.

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17.00 Care Coordination

Care Coordination ensures that Georgia Families 360° members receive needed services in a supportive, effective, efficient, timely and cost effective manner. Each member's Amerigroup Care Coordinator has the primary responsibility of ensuring the member's medical, behavioral, dental and overall health needs are met. DentaQuest will be providing daily reports and updates to ensure the Amerigroup Care Coordination Team has up to date information about the member's dental services. The Amerigroup Care Coordination Team will reach out to educate members, foster parents and adoptive parents about the service needs of the members.

The Amerigroup Care Coordinator will reach out to the primary care physician assigned to their charge, within 10 days of the member becoming eligible, to schedule the member's first health screening. A dental screening will be included in this initial appointment. Subsequently, the Amerigroup Care Coordinator will schedule the member's first dental appointment within 30 days of the screening to address any dental needs identified. The appointments scheduled by the Amerigroup Care Coordination Team (and My Health Direct) should be billed through DentaQuest, using the processes you are accustomed to.

Please remember, not all appointments will be scheduled by the Amerigroup Care Coordination Team. The member's guardian or the member his- or herself may schedule appointments as well.

The member's caregiver is responsible for signing the patients' medical history and financial responsibility paperwork.

There are three subgroups of members in Georgia Families 360°: those in the custody of the Department of Foster Care Services (DFCS), those who are overseen by the Department of Juvenile Justice (DJJ) and those who receive Adoption Assistance (AA). These members' guardians are defined as follows:

1. (DJJ) Department of Juvenile Justice- Biological Parent and/or DJJ Case Worker
2. (AA) Adoption Assistance- Adoptive Parent
3. (DFCS) Department of Foster Care Services - DFCS Case Worker
4. (DJJ & FC joint custody) - Department of Juvenile Justice and DFCS Case Worker

Providers can contact the Amerigroup Care Coordination Team at 1-855-661-2021 regarding Georgia Families 360° members.

18.00 Primary Care Dentist Assignment

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Primary Care Dentist (PCD) A Primary Care dentist is a licensed dentist who is the health care provider responsible for supervising and coordinating the initial and primary dental care to patients; for initiating referrals for specialty care; and for maintaining the continuity of patient care.

As a PCD, your role will be to work with the Amerigroup Care Coordination Team and DentaQuest to provide a Dental Home for each member of this program and ensure they are receiving proper oral health care.

PCD Auto-Assignment When DentaQuest is notified that a member is eligible for benefits, DentaQuest will assign a PCD to each member based upon the members' most recent dental visit or geographic access standards, if a PCD has not already been selected by the member his/her self.

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PCD Self-Selection Each member is encouraged to select a provider they wish to continue to visit as their PCD. To select a particular provider, members should follow the step-by-step instructions that have been made available through the Amerigroup member materials.

Through the member materials, they will be directed to visit the Member Web Portal to change or select a PCD. Members may also get assistance over the phone by calling the DentaQuest Member Services Call Center, and a representative will walk them through and assist them in selecting a PCD.

- Member Web Portal – [insert link]
- DentaQuest Member Services Call Center – **800.895.2218**

PCD Assignment Requests by Non-Members Any legal guardian and/or Amerigroup Care Coordinator who wishes to assign a PCD on a member's behalf, can do so through accessing the Member Web Portal or calling into the DentaQuest Member Services Call Center.

When a parent or guardian calls into the DentaQuest Member Services Call Center, a representative will verify a unique identifier in addition to other HIPAA compliance standards. This identifier will allow our representative to assist them in selecting a new PCD.

PCD Assignment Notification Once a PCD has been auto-assigned, a PCD Assignment letter will be generated in the Enterprise System. These letters will be sent to the Adoption Assistance members, indicating the assignment and providing the details for contacting the PCD.

PCD assignments, and any subsequent changes, will be indicated on a daily report that will be distributed to Amerigroup Care Coordination Team. All members will have access to their PCD assignment information via the DentaQuest Member Web Portal and Member Services phone line. The following Amerigroup member materials will direct them to this site:

- The Amerigroup Member Website
- The Amerigroup Member Handbook
- The Amerigroup Member Welcome Packet

PCD Termination Notification Should a provider term with the dental program, a PCD Termination letter will be generated is generated and delivered to members in the Adoption Assistance and standard Medicaid programs 30 days in advance of the provider's termination. These members will be instructed to select a new PCD.

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At this point, the member would have two days to select a new PCD, either through the DentaQuest Member Web Portal or by calling the Member Services Call Center. If in two days the member has not selected a PCD, DentaQuestl will auto-assign a new PCD within five days and send the PCD Assignment letter.

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APPENDIX A - ATTACHMENTS General Definitions

The following definitions apply to this Office Reference Manual:

A. "DCH" means Georgia Department of Community Health

B. "Contract" means the document specifying the services provided by DentaQuest to:

- an employer, directly or on behalf of the State of Missouri, as agreed upon between an employer or Plan and DentaQuest (a "Commercial Contract");
- a Medicaid beneficiary, directly or on behalf of a Plan, as agreed upon between the State of Georgia or its regulatory agencies or Plan and DentaQuest (a "Medicaid Contract");
- a Medicare beneficiary, directly or on behalf of a Plan, as agreed upon between the Center for Medicare and Medicaid Services ("CMS") or Plan and DentaQuest (a "Medicare Contract").

C. "Covered Services" is a dental service or supply that satisfies all of the following criteria:

 provided or arranged by a Participating Provider to a Member; authorized by DentaQuest in accordance with the Plan Certificate; and submitted to DentaQuest according to DentaQuest's filing requirements.

D. "DentaQuest" shall refer to DentaQuest of Georgia, LLC

E. "DentaQuest Service Area" shall be defined as the State of Georgia.

F. "Medically Necessary:" It is the responsibility of the health plan to determine whether or not a service(s) furnished or proposed to be furnished is (are) reasonable and medically necessary for the diagnosis or treatment of illness or injury, to improve the function of a malformed body member, or to minimize the progression of disability, in accordance with accepted standards of practice in the medical community of the area in which the health services are rendered; and service(s) could not have been omitted without adversely affecting the member's condition or the quality of medical care rendered; and service(s) is (are) furnished in the most appropriate setting.

G. "Member" means any individual who is eligible to receive Covered Services pursuant to a Contract and the eligible dependents of such individuals. A Member enrolled pursuant to a Commercial Contract is referred to as a "Commercial Member." A Member enrolled pursuant to a Medicaid Contract is referred to as a

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"Medicaid Member." A Member enrolled pursuant to a Medicare Contract is referred to as a "Medicare Member."

H. "Participating Provider" is a dental professional or facility or other entity, including a Provider, that has entered into a written agreement with DentaQuest, directly or through another entity, to provide dental services to selected groups of Members.

I. "Plan" is an insurer, health maintenance organization or any other entity that is an organized system which combines the delivery and financing of health care and which provides basic health services to enrolled Members for a fixed prepaid fee.

J. "Plan Certificate" means the document that outlines the benefits available to Members.

K. "Provider" means the undersigned health professional or any other entity that has entered into a written agreement with DentaQuest to provide certain health services to Members. Each Provider shall have its own distinct tax identification number.

L. "Provider Dentist" is a Doctor of dentistry, duly licensed and qualified under the applicable laws, who practices as a shareholder, partner, or employee of Provider, and who has executed a Provider Dentist Participation Addendum.

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New Appointment Guidelines

1) Patient Appointments; 2) Patient Wait Times; 3) After-Hours Phone Call Response Times

Patient Appointments for Standard Medicaid: **Routine** appointments must be made available within 21 days of request by the patient. **Emergency** appointments must be made available within 48 hours of request from patient.

Patient Appointments for Georgia Families 360° Medicaid: **Routine** appointments must be made available within 10 days of request by the patient. **Urgent** appointments must be made available within 48 hours of request by the patient. **Emergency** appointments must be made available within 24 hours of request from patient.

Patient In-Office Wait Times:

Scheduled appointments - Waiting times shall not exceed 60 minutes. After 30 minutes, patient must be given an update on waiting time with an option of waiting or rescheduling appointment.

Work-in or Walk-in - Waiting times shall not exceed 90 minutes. After 45 minutes, patient must be given an update on waiting time with an option of waiting or rescheduling appointment.

Patient After Hours Phone Calls: **Urgent** -provider should return call within 20 minutes. **All other calls**

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-provider should return call within 1 hour.

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Additional Resources

Welcome to the DentaQuest provider forms and attachment resource page. The links below provide methods to access and acquire both electronic and printable forms addressed within this document. To view copies please visit our website @ www.dentaquest.com. Once you have entered the website, click on the "Dentist" icon. From there choose your 'State" and press go. You will then be able to log in using your password and User ID. Once logged in, select the link "Related Documents" to access the following resources:

 Orthodontic Services Orthodontic Criteria Index Form Georgia Orthodontic Continuation of Care Form OrthoCAD Submission Form Dental Claim Form Instructions for Dental Claim Form Non – Covered Services Disclosures Form Provider Appeal Form Member Consent Form Hospital IV/Sedation Member Referral Evaluation Tool Initial Clinical Exam Form Recall Examination Form Authorization for Dental Treatment Direct Deposit Medical and Dental History Coverage Exception Request Form Provider Change Form Request for Transfer of Records

These forms may also be found within this manual.

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Orthodontic Services For Members Ages 0-20

Recipients with Medical Assistance, ages 0-20, who access their Early and Periodic Screening, Diagnosis and Treatment Program, (EPSDT) benefit may qualify for orthodontic care under the program, if medically necessary. Recipients must have a severe, dysfunctional, handicapping malocclusion. Any Medical Assistance recipient aged 0-20, who has had an appointment with a dentist, is considered to be an EPSDT participant and therefore eligible for orthodontics if medically necessary.

Since a case must be dysfunctional to be accepted for treatment, recipients whose molars and bicuspids are in good occlusion seldom qualify. Crowding alone is usually functional in spite of the aesthetic considerations.

All orthodontic services require prior authorization by one of DentaQuest's Dental Consultants. Orthodontic **services are only considered for those recipients with permanent dentitions.** The recipient should present with a fully erupted set of permanent teeth. At least ½ to ¾ of the clinical crown should be exposed, unless the tooth is impacted or congenitally missing. (Cleft palate cases and unusual oral-facial anomalies may receive special consideration for treatment during the transitional dentition).

The starting and billing date of orthodontic services is defined as the date when the bands, brackets, or appliances are placed in the recipient's mouth. The recipient must be eligible on this date of service.

Photographs, full mouth radiographs or panorex must be submitted with the request for prior authorization of services. Treatment should not begin prior to receiving notification from DentaQuest indicating coverage or non-coverage for the proposed treatment plan. **Dentists who begin treatment before receiving their approved (or denied) prior authorization are financially obligated to complete treatment at no charge to the patient; or face termination of their Provider Agreement.**

DentaQuest will utilize The "Ortho Criteria Index Form" (copy on following page) presently used to determine the presence of a handicapping malocclusion. A copy of the scoring sheet DentaQuest uses can be found on pages

Payment for orthodontics includes all appliances and all follow-up visits. Providers cannot bill for the replacement of removable orthodontic appliances and post-treatment maintenance retainers that are lost or damaged

If the case is denied, the prior authorization will be returned to the Provider indicating that the orthodontic treatment will not be covered by DentaQuest. However, an authorization will be issued for the payment of the radiographs and diagnostic models at a rate of $83.53.

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This image cannot currently be displayed.

First Review ___ Models ___ Second Review ___ Orthocad ___
Ceph Films ___ **X-Rays** ___
Photos ___ Narrative ___

DENTAQUEST ORTHODONTIC CRITERIA INDEX FORM GEORGIA – COMPREHENSIVE D8080

Patient Name: ________________________________

DOB:____________

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ABBREVIATIONS	CRITERIA	YES	NO
DO	Deep impinging overbite that shows palatal impingement of the majority of lower incisors.		
AO	True anterior openbite. (Not including one or two teeth slightly out of occlusion or where the incisors have not fully erupted).		
AX	Anterior crossbite. (Involves more than two teeth in crossbite or in cases where gingival stripping from the crossbite is demonstrated).		
IMP	Impacted incisors or canines that will not erupt into the arches without orthodontic or surgical intervention. (Does not include cases where incisors or canines are going to erupt ectopically).		
OJ	Overjet in excess of 9 mm.		
NO	Negative Overjet greater than 3.5mm.		
LL	Cleft Lip/Palate deformities and other significant craniofacial anomalies.		
FAS	Malocclusions requiring a combination orthodontic and orthognathic surgery for correction.		

APPROVED: **DENIED:**

Kathie Arena, DDS David Bogenschutz, DDS Thomas Gengler, DDS James Thommes, DDS

Richard Nellen, DDS Paul Schulze, DDS

Patient Information

Name (First & Last)	Date of Birth:	SS or ID#
Address:	**City, State, Zip**	**Area code & Phone number:**
Group Name:	**Plan Type:**	

Provider Information

Dentist Name:	Provider NPI #	Location ID #
Address:	**City, State, Zip**	**Area code & Phone number:**

Treatment Requested

ABBREVIATIONS	CRITERIA
DO	Deep impinging overbite that shows palatal impingement of the majority of lower i
AO	True anterior openbite. (Not including one or two teeth slightly out of occlusi incisors have not fully erupted).
AX	Anterior crossbite. (Involves more than two teeth in crossbite or in cases w from the crossbite is demonstrated).

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ABBREVIATIONS	CRITERIA
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LL	Cleft Lip/Palate deformities and other significant craniofacial anomalies.
FAS	Malocclusions requiring a combination orthodontic and orthognathic surgery for correction.

APPROVED: **DENIED:**

Kathie Arena, DDS David Bogenschutz, DDS Thomas Gengler, DDS James Thommes, DDS

Richard Nellen, DDS Paul Schulze, DDS

Patient Information		
Name (First & Last)	**Date of Birth:**	**SS or ID#**
Address:	**City, State, Zip**	**Area code & Phone number:**
Group Name:	**Plan Type:**	

Provider Information		
Dentist Name:	**Provider NPI #**	**Location ID #**

OrthoCAD Submission Form

Date:____________________

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Continuation of Care Submission Form

ABBREVIATIONS	CRITERIA	YES	NO
DO	Deep impinging overbite that shows palatal impingement of the majority of lower incisors.		
AO	True anterior openbite. (Not including one or two teeth slightly out of occlusion or where the incisors have not fully erupted).		
	Anterior crossbite (Involves more than two teeth in crossbite or in cases where gingival stripping		

ABBREVIATIONS	CRITERIA	YES	NO
DO	Deep impinging overbite that shows palatal impingement of the majority of lower incisors.		

Date:__________________ Patient Information

Provider Information

Name of Previous Vendor that issued original approval: Banding

Date:

Case Rate Approved By Previous Vendor: Amount Paid

for Dates of Service That Occurred Prior to DentaQuest: Amount Owed for Dates of Service That Occurred Prior to

DentaQuest: Balance Expected for Future Dates of Service: Remaining services and quantities to be paid from prior

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approval:

Additional information required:

☐ If the member is transferring from an existing Medicaid program: A copy of the original orthodontic approval.

☐ If the member is private pay or transferring from a commercial insurance program Original diagnostic photos or models (or OrthoCad equivalent), radiographs (optional).

Mail to: DentaQuest, LLC Attn: Continuation 11100 W. Liberty Drive Milwaukee, WI 53224

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Hospital / IV Sedation Member Referral Evaluation Tool

Member Name:

ID Number:
Provider Name:

Factors:

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Age:	
Age:	**Points** (Circle choice)
0 - 3 yrs	7
4 - 5 yrs	5
6 - 7 yrs	3
8 - 9 yrs	1
10 + yrs	0

Health Complications (Documented with MD Letter)	
Medically compromised/handicapping condition	**Points** (Circle choice)
History of Uncontrolled Bleeding	13
Cerebral Palsy	13
Asthma/Breathing Problems	9
Autism/ADHD	8
Heart/Blood Pressure Problems	8
Moderate Retardation	8
Mild Retardation	6
Anxiety (situational)	5

Services required (total # of teeth restored and extractions)	
	Points (Circle choice)
Services - 13 +	10
Services - 10 - 12	9
Services - 7 - 9	7
Services - 4 - 6	5

Documentation of medical necessity- *REQUIRED*	
Clinical notes from dentist demonstrating failed trial for dental services in dental office setting.	5

Total Score:	
Eligible for outpatient hospital procedure	**15 points or more**
DQ Dentist authorizing outpatient hospital dental service approval:	______________________

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American Dental Association
www.ada.org

Comprehensive completion instructions for the ADA Dental Claim Form are found in Section 4 of the ADA Publication titled *CDT-2007/2008*. Five relevant extracts from that section follow:

GENERAL INSTRUCTIONS

A. The form is designed so that the name and address (Item 3) of the third-party payer receiving the claim (insurance company/dental benefit plan) is visible in a standard #10 window envelope. Please fold the form using the 'tick-marks' printed in the margin.
B. In the upper-right of the form, a blank space is provided for the convenience of the payer or insurance company, to allow the assignment of a claim or control number.
C. All Items in the form must be completed unless it is noted on the form or in the following instructions that completion is not required.
D. When a name and address field is required, the full name of an individual or a full business name, address and zip code must be entered.
E. All dates must include the four-digit year.
F. If the number of procedures reported exceeds the number of lines available on one claim form, the remaining procedures must be listed on a separate, fully completed claim form.

COORDINATION OF BENEFITS (COB)

When a claim is being submitted to the secondary payer, complete the form in its entirety and attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may indicate the amount the primary carrier paid in the "Remarks" field (Item # 35).

NATIONAL PROVIDER IDENTIFIER (NPI)

49 and 54 NPI (National Provider Indentifier): This is an identifier assigned by the Federal government to all providers considered to be HIPAA covered entities. Dentists who are not covered entities may elect to obtain an NPI at their discretion, or may be enumerated if required by a participating provider agreement with a third-party payer or applicable state law/regulation. An NPI is unique to an individual dentist (Type 1 NPI) or dental entity (Type 2 NPI), and has no intrinsic meaning. Additional information on NPI and enumeration can be obtained from the ADA's Internet Web Site: **www.ada.org/goto/npi**

ADDITIONAL PROVIDER IDENTIFIER

52A and 58 Additional Provider ID: This is an identifier assigned to the billing dentist or dental entity other than a Social Security Number (SSN) or Tax Identification Number (TIN). It is not the provider's NPI. The additional identifier is sometimes referred to as a Legacy Identifier (LID). LIDs may not be unique as they are assigned by different entities (e.g., third-party payer; Federal government). Some Legacy IDs have an intrinsic meaning.

PROVIDER SPECIALTY CODES

56A Provider Specialty Code: Enter the code that indicates the type of dental professional who delivered the treatment. Available codes describing treating dentists are listed below. The general code listed as 'Dentist' may be used instead of any other dental practitioner code.

Category / Description Code	Code
Dentist A dentist is a person qualified by a doctorate in dental surgery (D.D.S) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license.	122300000X
General Practice	1223G0001X
Dental Specialty (see following list)	Various
Dental Public Health	1223D0001X
Endodontics	1223E0200X
Orthodontics	1223X0400X
Pediatric Dentistry	1223P0221X
Periodontics	1223P0300X
Prosthodontics	1223P0700X
Oral & Maxillofacial Pathology	1223P0106X
Oral & Maxillofacial Radiology	1223D0008X
Oral & Maxillofacial Surgery	1223S0112X

Dental provider taxonomy codes listed above are a subset of the full code set that is posted at: **www.wpc-edi.com/codes/taxonomy**

Should there be any updates to ADA Dental Claim Form completion instructions, the updates will be posted on the ADA's web site at: **www.ada.org/goto/dentalcode**

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Non-Covered Service Disclosure Form

The Member may purchase additional services as a non-covered procedure/s or treatment/s for an additional charge. DentaQuest requires that you and the member complete the **Non-Covered Services Disclosure Form** prior to rendering these services. A copy of this form must be kept in the Member's treatment record. If the Member elects to receive the non-covered procedure/s or treatment/s the member would pay a fee not to exceed the maximum rate of your usual and customary fees as payment in full for the agreed procedure/s or treatment/s. The Member is financially responsible for such services. If the Member will be subject to collection action upon failure to make the required payment, the terms of the action must be kept in the Member's treatment record. Failure to comply with this procedure will subject the provider to sanctions up to and including termination.

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Non – Covered Services Disclosures Form

<u>This section to be completed by dentist rendering care</u>

I am recommending that ____ receive
(Member Name and Medicaid Number)
services that are **not** covered by the DentaQuest Covered Benefits and Fee Schedule. The following procedure codes are recommended: FEES NOT TO EXCEED PROVIDER'S UCF (usual and customary fee).

The total amount for service(s) to be rendered is $_______________. Doctor's Signature Date

<u>This section to be completed by member</u>

I ____, have been told that I require
(Print Name)
services or have requested services that are not covered by the DentaQuest Covered Benefits and Fee Schedule.

Read the following questions and check either Yes or No:

ABBREVIATIONS	CRITERIA	YES	NO
DO	Deep impinging overbite that shows palatal impingement of the majority of lower incisors.		
AO	True anterior openbite. (Not including one or two teeth slightly out of occlusion or where the incisors have not fully erupted).		
AX	Anterior crossbite. (Involves more than two teeth in crossbite or in cases where gingival stripping		

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I agree to pay $_______________ per month. **If I fail to make this payment I may be subject to collection action.**

Patient's Signature if over 18 or Parent or Guardian Date

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COVERAGE EXCEPTION REQUEST FORM

Member Name	Medicaid ID No.	DOB

Provider Name	Provider ID No.	Location Name & Address

☑	Code	Description	Documentation Required
☐	D0150	Comprehensive Oral Evaluation	If submitted by same dentist or group, narrative description of established patient's significant change in health conditions or unusual circumstances.
☐	D0210	Intraoral - Complete Series	Narrative of medical necessity for complete series radiographs under age 6.
☐	D0272	Bitwings - Two Films	Narrative of medical necessity for two bitewing films under age 2.
☐	D0274	Bitewings - Four Films	Narrative of medical necessity for four bitewing films under age 10.
☐	D0330	Panoramic Film	Narrative of medical necessity for panoramic film under age 6.
☐	D1203	Topical Application of Fluoride - Child	Narrative confirming existence of primary dentition for patient over age 13 and dated radiograph showing at least one retained deciduous tooth.

Narrative

Signature of Treating Dentist	Date

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DentaQuest Provider Appeal Form

DentaQuest Attn: Complaints & Grievances 11100 W. Liberty Drive, Milwaukee, WI 53224

Member Name: ____

Member Identification Number: _________________________________ **Date of**

Service: ____ **Date EOB**

was received: ____ **Authorization**

Number: ____ **Date Authorization**

was received: ________________________________

Provider Name: ____

Location Number: ____ **Office**

Contact: ____ **Office**

Phone Number: ____

Reason for Appeal:

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Outcome office is requesting:

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Consent for Provider to File Appeal

For a provider to file an appeal for a member, the member must give their written consent. The consent can be in any form as long as it contains the following: specifics of the service being appeals, such as the type of service, date of service, provider of the service; member's name; member's signature; date of signature. Below if a sample consent form.

CONSENT

I, __________________(Member Name), give ____________________(Provider Name) permission to appeal on my behalf the following action: Denial of orthodontics (braces)

Member Signature Date

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A-15 A-16

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ALLERGY	PRE MED	MEDICAL ALERT

INITIAL CLINICAL EXAM

PATIENT'S NAME ______________________________
Last First Middle

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

B L

A B C D E F G H I J

RIGHT LEFT

T S R Q P O N M L K

L B

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

GINGIVA

MOBILITY

PROTHESIS EVALUATION

OCCLUSION 1 11 111

PATIENT'S CHIEF COMPLAINT

	OK
LYMPH NODES	
PHARYNX	
TONSILS	
SOFT PALATE	
HARD PALATE	
FLOOR OF MOUTH	
TONGUE	
VESTIBULES	
BUCCAL MUCOSA	
LIPS	
SKIN	
TMJ	
ORAL HYGIENE	
PERIO EXAM	

CLINICAL FINDINGS/COMMENTS

RADIOGRAPHS	B/P	RDH/DDS

RECOMMENDED TREATMENT PLAN

TOOTH OR AREA	DIAGNOSIS	PLAN A	PLAN B

SIGNATURE OF DENTIST ______________________________ DATE

Note: The above form is intended to be a sample. DentaQuest is not mandating the use of this form. Please refer to State statutes for specific State requirements and guidelines.

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RECALL EXAMINATION

ABBREVIATIONS	CRITERIA
DO	Deep impinging overbite that shows palatal impingement of the majority of lower incisors.
AO	True anterior openbite. (Not including one or two teeth slightly out of occlusion or where the incisors have not fully erupted).
AX	Anterior crossbite. (Involves more than two teeth in crossbite or in cases where gingival stripping from the crossbite is demonstrated).
IMP	Impacted incisors or canines that will not erupt into the arches without orthodontic or surgical intervention. (Does not include cases where incisors or canines are going to erupt ectopically).
OJ	Overjet in excess of 9 mm

ABBREVIATIONS	CRITERIA
DO	Deep impinging overbite that shows palatal impingement of the majority of lower incisors.
	True anterior openbite. (Not including one or two teeth slightly out of occlusion or where the

PATIENT'S NAME____ CHANGES IN

HEALTH STATUS/MEDICAL HISTORY ____

R WORK NECESSARY L

COMMENTS:____

RECALL EXAMINATION

PATIENT'S NAME____ CHANGES IN

HEALTH STATUS/MEDICAL HISTORY ____

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R WORK NECESSARY L

COMMENTS:____

NOTE: The above form is intended to be a sample. DentaQuest is not mandating the use of this form. Please refer to State statutes for specific State requirements and guidelines.

ABBREVIATIONS	CRITERIA
DO	Deep impinging overbite that shows palatal impingement of the majority of lower incisors.
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IMP	Impacted incisors or canines that will not erupt into the arches without orthodontic or surgical intervention. (Does not include cases where incisors or canines are going to erupt ectopically).
OJ	Overjet in excess of 9 mm

ABBREVIATIONS	CRITERIA
DO	Deep impinging overbite that shows palatal impingement of the majority of lower incisors.

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Authorization for Dental Treatment

I hereby authorize Dr. ___________________________ and his/her associates to provide dental services, prescribe, dispense and/or administer any drugs, medicaments, antibiotics, and local anesthetics that he/she or his/her associates deem, in their professional judgement, necessary or appropriate in my care.

I am informed and fully understand that there are inherent risks involved in the administration of any drug, medicament, antibiotic, or local anesthetic. I am informed and fully understand that there are inherent risks involved in any dental treatment and extractions (tooth removal). The most common risks can include, but are not limited to:

> Bleeding, swelling, bruising, discomfort, stiff jaws, infection, aspiration, paresthesia, nerve disturbance or damage either temporary or permanent, adverse drug response, allergic reaction, cardiac arrest.

I realize that it is mandatory that I follow any instructions given by the dentist and/or his/her associates and take any medication as directed.

Alternative treatment options, including no treatment, have been discussed and understood. No guarantees have been made as to the results of treatment. A full explanation of all complications is available to me upon request from the dentist.

Procedure(s): ____

Tooth Number(s): ____

Date: _____________________________________

Dentist: __________________________________

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Patient Name: ______________________________

Legal Guardian/ Patient Signature: ____________________________

Witness: ___________________________________

Note: The above form is intended to be a sample. DentaQuest is not mandating the use of this form. Please refer to State statutes for specific State requirements and guidelines.

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AUTHORIZATION TO HONOR DIRECT AUTOMATED CLEARING HOUSE (ACH) CREDITS DISBURSED BY DENTAQUEST OF GEORGIA, LLC

INSTRUCTIONS

1. Complete all parts of this form.
2. Execute all signatures where indicated. If account requires counter signatures, both signatures must appear on this form.
3. **IMPORTANT:** Attach voided check from checking account.

MAINTENANCE TYPE:

__________ Add __________ Change (Existing Set Up) __________ Delete (Existing Set Up)

ACCOUNT HOLDER INFORMATION:

Account Number: ____ Account Type: __________ Checking

Bank Routing Number: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

__________ Personal

__________ Business (choose one)

Bank Name: ____ Account Holder Name: ____ Effective Start Date: ____ As a convenience to me, for payment of services or goods due me, I hereby request and authorize **DentaQuest of Georgia, LLC** to credit

my bank account via Direct Deposit for the (agreed upon dollar amounts and dates.) I also agree to accept my remittance statements online and understand paper remittance statements will no longer be processed. This authorization will remain in effect until revoked by me in writing. I agree you shall be fully protected in honoring any such credit entry.

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I understand in endorsing or depositing this check that payment will be from Federal and State funds and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws.

I agree that your treatment of each such credit entry, and your rights in respect to it, shall be the same as if it were signed by me. I fully agree that if any such credit entry be dishonored, whether with or without cause, you shall be under no liability whatsoever.

ABBREVIATIONS	CRITERIA	YES	N
DO	Deep impinging overbite that shows palatal impingement of the majority of lower incisors.		
AO	True anterior openbite. (Not including one or two teeth slightly out of occlusion or where the incisors have not fully erupted).		
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OJ	Overjet in excess of 9 mm.		
NO	Negative Overjet greater than 3.5mm.		

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MEDICAL AND DENTAL HISTORY

Patient Name: _________________________________ Date of Birth: ___________________ Address:

____

Why are you here today? ____ Are you having pain or discomfort at this time? Yes No

If yes, what type and where? ____ Have you been under the care of a medical doctor during the past two years? Yes No

Medical Doctor's Name: ____

Address: ____

Telephone: ____

Have you taken any medication or drugs during the past two years? � Yes � No Are you now taking any medication, drugs, or pills? � Yes � No If yes, please list medications: ____ Are you aware of being allergic to or have you ever reacted badly to any medication or substance? Yes � No If yes, please list: ____

When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness or breath, or because you are very tired? Yes No Do your ankles swell during the day? Yes No Do you use more than two pillows to sleep? Yes No Have you lost or gained more than 10 pounds in the past year? Yes No Do you ever wake up from sleep and feel short of breath? Yes No Are you on a special diet? Yes

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No Has your medical doctor ever said you have cancer or a tumor?   Yes   No

If yes, where? ____ Do you use tobacco products (smoke or chew tobacco)?   Yes   No

If yes, how often and how much? ________________________________ Do you drink alcoholic beverages (beer, wine, whiskey, etc.)?   Yes   No

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Do you have or have you had any disease, or condition not listed? Yes No

If yes, please list: ____ Indicate which of the following your have had, or have at present. Circle “Yes” or “No” for each item.

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ABBREVIATIONS	CRITERIA	YES	NO
DO	Deep impinging overbite that shows palatal impingement of the majority of lower incisors.		
AO	True anterior openbite. (Not including one or two teeth slightly out of occlusion or where the incisors have not fully erupted).		
AX	Anterior crossbite. (Involves more than two teeth in crossbite or in cases where gingival stripping from the crossbite is demonstrated).		
IMP	Impacted incisors or canines that will not erupt into the arches without orthodontic or surgical intervention. (Does not include cases where incisors or canines are going to erupt ectopically).		
OJ	Overjet in excess of 9 mm.		
NO	Negative Overjet greater than 3.5mm.		
LL	Cleft Lip/Palate deformities and other significant craniofacial anomalies.		
FAS	Malocclusions requiring a combination orthodontic and orthognathic surgery for correction.		

APPROVED: **DENIED:**

Kathie Arena, DDS
David Bogenschutz, DDS
Thomas Gengler, DDS
James Thommes, DDS
Richard Nellen, DDS
Paul Schulze, DDS

Patient Information		
Name (First & Last)	**Date of Birth:**	**SS or ID#**
Address:	**City, State, Zip**	**Area code & Phone number:**
Group Name:	**Plan Type:**	

Provider Information		
Dentist Name:	**Provider NPI #**	**Location ID #**
Address:	**City, State, Zip**	**Area code & Phone number:**

Treatment Requested	
Code:	**Description of request:**

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For Women Only:
Are you pregnant? Yes No
If yes, what month? ____ Are you nursing? Yes No Are you taking birth control pills? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully.

Patient Signature: ______________________________ Date: __________________________ Dentist's Signature: ______________________________ Date: __________________________

Note: The above form is intended to be a sample. DentaQuest is not mandating the use of this form. Please refer to State statutes for specific State requirements and guidelines.

ABBREVIATIONS	CRITERIA

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Provider Change Form

Provider Name ______________________________

Provider NPI ______________________________

Tax ID ______________________________

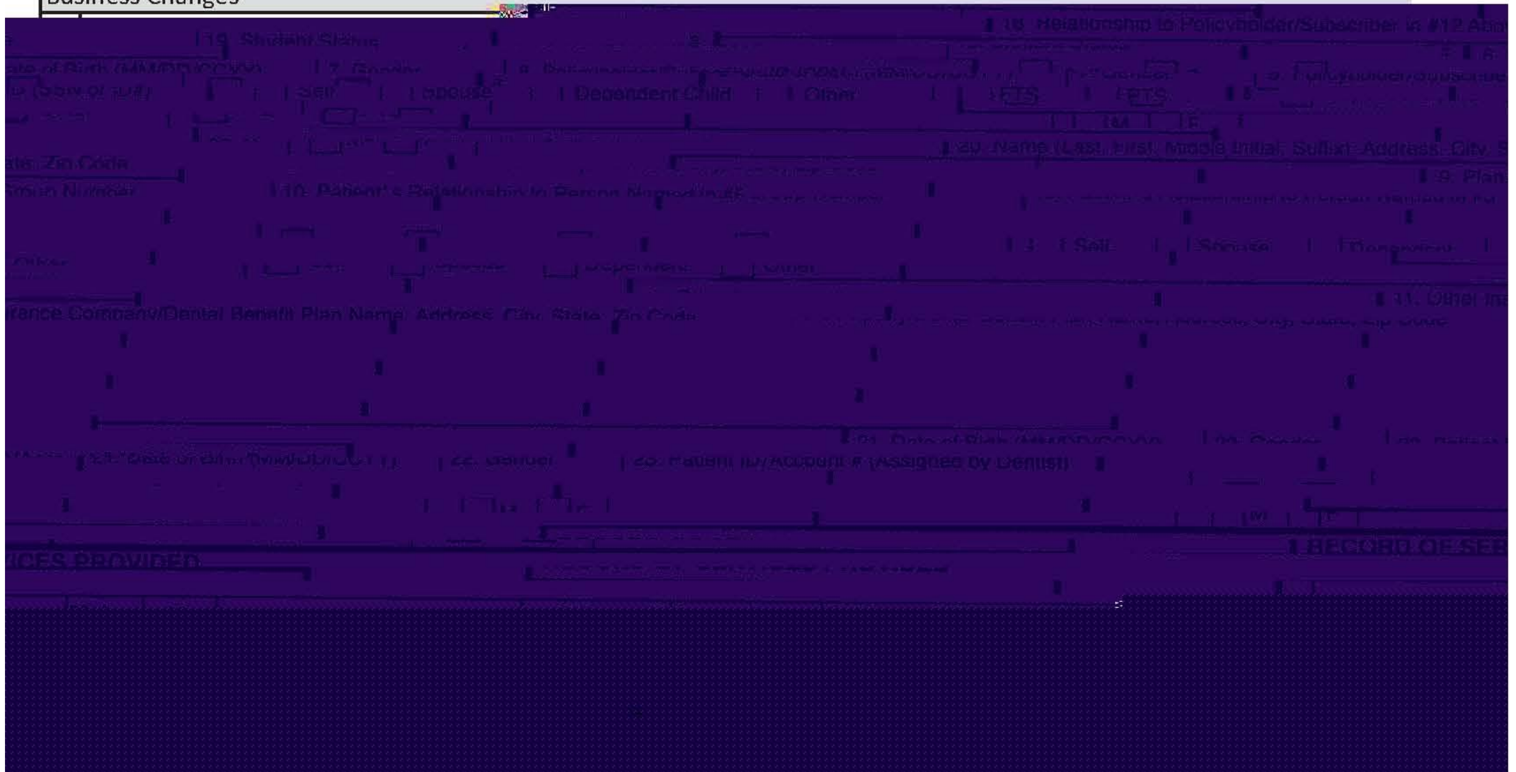
Location Address ______________ **GID #** ______________

Location Address ______________ **GID#** ______________

Location Address ______________ **GID#** ______________

Please check the box preceeding the change (s) you would like to have made to the providers record.

		Current Info	New Info	Effective Date
Provider Demographic Changes				
☐	Name (provide proof of name change)			
☐	Date of Birth			
☐	Degree			
☐	Social Security #			
☐	Gender			
☐	Medicaid number update			
☐	Dental Home Update			
☐	Provider NPI			
☐	Correspondence Address			
Provider License Updates				
☐	Dental License			
☐	DEA			
☐	Anesthesia License			
Location Changes				
☐	Service Office name			
☐	Service office Address			
☐	Phone number			
☐	Fax Number			
☐	Age Limitations			
☐	Office Hours			
☐	Not on directory			
☐	Existing Patients Only			
☐	Term provider from this location			
☐	Dental Home/ Capitation Attributes			
Business Changes				



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Request for Transfer of Records

I, _____________________________, hereby request and give my permission to Dr. _________________________ to provide Dr._______________________________________ any and all information regarding past dental care for ______________________________.

Such records may include medical care and treatment, illness or injury, dental history, medical history, consultation, prescriptions, radiographs, models and copies of all dental records and medical records.

Please have these records sent to:

__________________________________ Date: _________________________ (Patient) Signed:

__________________________________ Date: _________________________ (Parent, Legal Guardian or Custodian of the Patient, if Patient is a Minor)

Address: ____ Address:

____ Phone:

____

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APPENDIX B

Covered Benefits (See Exhibits A – J)

This section identifies covered benefits, provides specific criteria for coverage and defines individual age and benefit limitations for Members under age 21. **Providers with benefit questions should contact DentaQuest's Customer Service department directly at:**

800.516.0124, press option 2

Dental offices are not allowed to charge Members for missed appointments. Plan Members are to be allowed the same access to dental treatment, as any other patient in the dental practice. Private reimbursement arrangements may be made only for non-covered services.

DentaQuest recognizes tooth letters "A" through "T" for primary teeth and tooth numbers "1" to "32" for permanent teeth. Supernumerary teeth should be designated by "AS through TS" for primary teeth and tooth numbers "51" to "82" for permanent teeth. These codes must be referenced in the patient's file for record retention and review. **All dental services performed must be recorded in the patient record, which must be available as required by your Participating Provider Agreement.**

For reimbursement, DentaQuest Providers should bill only per unique surface regardless of location. For example, when a dentist places separate fillings in both occlusal pits on an upper permanent first molar, the billing should state a **one** surface occlusal amalgam ADA code D2140. Furthermore, DentaQuest will reimburse for the total number of surfaces restored per tooth, per day; (i.e. a separate occlusal and buccal restoration on tooth 30 will be reimbursed as 1 (OB) two surface restoration).

The DentaQuest claim system can only recognize dental services described using the current American Dental Association CDT code list or those as defined as a Covered Benefit. All other service codes not contained in the following tables will be rejected when submitted for payment. A complete, copy of the CDT book can be purchased from the American Dental Association at the following address:

American Dental Association 211 East
Chicago Avenue Chicago, IL 60611
800.947.4746

Furthermore, DentaQuest subscribes to the definition of services performed as described in the CDT manual.

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The benefit tables (Exhibits A - J) are all inclusive for covered services. Each category of service is contained in a separate table and lists:

1. the ADA approved service code to submit when billing,
2. brief description of the covered service,
3. any age limits imposed on coverage,
4. a description of documentation, in addition to a completed ADA claim form, that must be submitted when a claim or request for prior authorization is submitted,
5. an indicator of whether or not the service is subject to prior authorization, any other applicable benefit limitations.

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DentaQuest Authorization Process

IMPORTANT

For procedures where “Authorization Required” fields indicate “**yes**”.

Please review the information below on when to submit documentation to DentaQuest. The information refers to the “Documentation Required” field in the Benefits Covered section (Exhibits A - J). In this section, documentation may be requested to be sent prior to beginning treatment or “with claim” after completion of treatment.

ABBREVIATIONS	CRITERIA	YES	NO
DO	Deep impinging overbite that shows palatal impingement of the majority of lower incisors.		
AO	True anterior openbite. (Not including one or two teeth slightly out of occlusion or where the incisors have not fully erupted).		
AX	Anterior crossbite. (Involves more than two teeth in crossbite or in cases where gingival stripping from the crossbite is demonstrated).		

ABBREVIATIONS	CRITERIA	YES	NO
DO	Deep impinging overbite that shows palatal impingement of the majority of lower incisors.		
AO	True anterior openbite. (Not including one or two teeth slightly out of occlusion or where the incisors have not fully erupted).		
	Anterior crossbite. (Involves more than two teeth in crossbite or in cases where gingival stripping		

When documentation is requested:

When documentation is requested “with claim:”

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Exhibit A Benefits Covered for
Amerigroup Children's Medicaid

Diagnostic services include the oral examinations, school based examinations and selected radiographs needed to assess the oral health, diagnose oral pathology and develop an adequate treatment plan for the Participant's oral health.

Reimbursement for radiographs includes exposure of the radiograph, developing, mounting and radiographic interpretation. Reimbursement for multiple radiographs of the same tooth or area may be denied if DentaQuest determines the number to be redundant, excessive or not in keeping with the federal policies relating to radiation exposure. DentaQuest utilizes the guidelines published by the Department of Health and uman Services, Center for Devices and Radiological Health. These guidelines were developed in conjunction with the Food and Drug Administration and are described in Attachment J of this manual.

If the total allowed amount for radiographs performed on a participant exceeds the allowed amount for procedure code D0210 (Complete Series), the submitted radiograph codes will be consolidated and paid as a Complete Series (D0210). The maximum reimbursement for a single date of service for radiographs shall be limited to the fee for a complete series.

A comprehensive oral evaluation (D0150) is typically used when evaluating a patient comprehensively. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. It may require interpretation of information acquired through additional diagnostic procedures. Additional diagnostic procedures should be reported separately.

This would include the evaluation and recording of the patient's dental and medical history and a general health assessment. It may typically include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, oral cancer screening, etc.

A periodic oral evaluation (D0120) is performed on a patient of record to determine any changes in the patient's dental and medical health status since a previous comprehensive or periodic evaluation. This may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately.

A complete Early Periodic Screening, Diagnosis and Treatment (EPSDT) school based examination is used when evaluating a patient comprehensively. It is a thorough evaluation and a recording of the extraoral and intraoral hard and soft tissues. This would include the evaluation and recording of the patient's dental and medical history and a general health assessment. It may typically include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, oral cancer screening, etc. if medically necessary to render D0150, D0210, D0272, D0274, D0330, or D1203 outside of established age parameters. Coverage Exception Request Form may be submitted prospectively for consideration (see Appendix- A 13)

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0120	periodic oral evaluation - established patient	0-20		No	One of (D0120, D0150) per 6 Month(s) Per patient. Either D0120 or D0150.	
D0140	limited oral evaluation-problem focused	0-20		No	Two of (D0140) per 1 Year(s) Per patient.	

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Exhibit A Benefits Covered for Amerigroup Children's Medicaid

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0150	comprehensive oral evaluation - new or established patient	0-20		No	One of (D0150) per 1 Lifetime Per Provider OR Location. One of (D0120, D0150) per 6 Month(s) Per patient.	
D0210	intraoral - complete series of radiographic images	6 - 20		No	One of (D0210) per 36 Month(s) Per patient. One of (D0210, D0330) per 36 Month(s) Per patient.	
D0220	intraoral - periapical first radiographic image	0-20		No		
D0230	intraoral - periapical each additional radiographic image	0-20		No		
D0240	intraoral - occlusal radiographic image	0-20		No		
D0270	bitewing - single radiographic image	0-20		No	One of (D0270, D0272, D0274) per 6 Month(s) Per patient.	
D0272	bitewings - two radiographic images	2 - 20		No	One of (D0270, D0272, D0274) per 6 Month(s) Per patient.	
D0274	bitewings - four radiographic images	10 - 20		No	One of (D0270, D0272, D0274) per 6 Month(s) Per patient.	
D0330	panoramic radiographic image	6 - 20		No	One of (D0330) per 36 Month(s) Per patient. One of (D0210, D0330) per 36 Month(s) Per patient.	

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Exhibit A Benefits Covered for
Amerigroup Children's Medicaid

Preventive services include routine and EPSDT prophylaxis (including scaling and polishing), topical fluoride treatments, dental sealants, and space maintenance therapy. The goal of providing routine and periodic preventive dental services is to maintain oral health and prevent more extensive dental procedures.

Routine prophylaxis is covered for Participants age 0 through 20, once per 6 months. Prophylaxis includes necessary scaling and polishing.

The topical application of fluoride treatment is allowed once per 6 months for Participants age 2 through 13.

Sealants are covered for Participants age 5 through 17. Sealants should be applied to the occlusal surfaces of all erupted and appropriate first and second permanent molars. Priority should be given to applying sealants for all 7 and 12 year olds. Sealants will not be covered when they are placed over restorations.

A lower lingual holding arch placed when there is not premature loss of a primary molar is considered a transitional orthodontic appliance and not a covered benefit.

PLACE OF SERVICE (field #38 on 2002, 2004 ADA claim form) MUST BE INDICATED ON ALL CLAIMS.

THE DATE OF PLACEMENT MUST BE USED AS THE DATE OF SERVICE WHEN SUBMITTING FOR PAYMENT OF SPACE MAINTAINERS.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Preventative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1110	prophylaxis - adult	14 - 20		No	One of (D1110) per 6 Month(s) Per patient.	
D1120	prophylaxis - child	0-13		No	One of (D1120) per 6 Month(s) Per patient. Removal of plaque, calculus and stains from the tooth surfaces. Intended to control local irrational factors.	
D1206	topical application of fluoride varnish	0-13		No	One of (D1203, D1206, D1208) per 6 Month(s) Per patient.	
D1208	topical application of fluoride - excluding varnish	2-13		No	One of (D1203, D1206, D1208) per 6 Month(s) Per patient. Prescription strength fluoride designed soley for use in the dental office, delivered to the dentition under the direct supervision of a dental professional.	
D1351	sealant - per tooth	5-17	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	One of (D1351) per 4 Year(s) Per patient per tooth. Occlusal surfaces only. Teeth must be caries free. Sealant will not be covered when placed over restorations.	

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Exhibit A Benefits Covered for Amerigroup Children's Medicaid

Preventative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1510	space maintainer-fixed-unilateral	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	Covered when indicated due to premature loss of posterior primary teeth.	
D1515	space maintainer - fixed - bilateral	0-20	Per Arch (01, 02, LA, UA)	No	Covered when indicated due to premature loss of posterior primary teeth.	
D1525	space maintainer-removable-bilateral	0-20	Per Arch (01, 02, LA, UA)	No	Covered when indicated due to premature loss of posterior primary teeth.	
D1550	re-cement or re-bond space maintainer	0-20		No	Covered when indicated due to premature loss of posterior primary teeth.	

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Restorative services (amalgams and composites) are provided to remove decay and restore dental structures (teeth) to a reasonable condition. Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day.

When restorations involving multiple surfaces are requested or performed, that are outside the usual anatomical expectation, the allowance is limited to that of a one-surface restoration. Any fee charged in excess of the allowance for the one-surface restoration is DISALLOWED.

Bases, cements, liners, pulp caps, bonding agents and local anesthetic are included in the restorative service fees and are not reimbursed separately.

Generally, once a particular restoration is placed in a tooth, a similar restoration will not be covered for at least 12 months. Restorations are expected to last a reasonable amount of time. Repeated unexplained failures will result in review by Peer Review and may necessitate removal of the dentist from the panel.

The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent teeth.

BILLING AND REIMBURSEMENT FOR CAST CROWNS, CAST POST & CORES AND LAMINATE VENEERS OR ANY OTHER FIXED PROSTHETICS SHALL BE BASED ON THE CEMENTATION DATE.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2140	Amalgam - one surface, primary or permanent	0-20	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. One restorative filling per tooth per restoration. Max number of surfaces to be reimbursed is 4.	
D2150	Amalgam - two surfaces, primary or permanent	0-20	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. One restorative filling per tooth per restoration. Max number of surfaces to be reimbursed is 4.	
D2160	amalgam - three surfaces, primary or permanent	0-20	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. One restorative filling per tooth per restoration. Max number of surfaces to be reimbursed is 4.	

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Exhibit A Benefits Covered for
Amerigroup Children's Medicaid

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2161	amalgam - four or more surfaces, primary or permanent	0-20	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. One restorative filling per tooth per restoration. Max number of surfaces to be riembursed is 4.	
D2330	resin-based composite - one surface, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. One restorative filling per tooth per restoration. Max number of surfaces to be reimbursed is 4.	
D2331	resin-based composite - two surfaces, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. One restorative filling per tooth per restoration. Max number of surfaces to be reimbursed is 4.	
D2332	resin-based composite - three surfaces, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. One restorative filling per tooth per restoration. Max number of surfaces to be reimbursed is 4.	
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2391	resin-based composite - one surface, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. One restorative filling per tooth per restoration. Max number of surfaces to be reimbursed is 4.	

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Exhibit A Benefits Covered for Amerigroup Children's Medicaid

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2392	resin-based composite - two surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. One restorative filling per tooth per restoration. Max number of surfaces to be reimbursed is 4.	
D2393	resin-based composite - three surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2394	resin-based composite - four or more surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. One restorative filling per tooth per restoration. Max number of surfaces to be reimbursed is 4.	
D2920	re-cement or re-bond crown	0-20	Teeth 1 - 32, A - T	No	One restorative filling per tooth per restoration. Max number of surfaces to be reimbursed is 4.	
D2930	prefabricated stainless steel crown - primary tooth	0-20	Teeth A - T	No	One of (D2930, D2934) per 1 Lifetime Per Provider OR Location per tooth.	
D2931	prefabricated stainless steel crown-permanent tooth	2 - 20	Teeth 1 - 32	No	One of (D2931) per 60 Month(s) Per Provider OR Location per tooth. One restorative filling per tooth per restoration. Max number of surfaces to be reimbursed is 4.	
D2932	prefabricated resin crown	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2932) per 60 Month(s) Per Provider OR Location per tooth.	
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	0-20	Teeth A - T	No	One of (D2930, D2934) per 1 Lifetime Per Provider OR Location per tooth. One restorative filling per tooth per restoration. Max number of surfaces to be reimbursed is 4	
D2940	protective restoration	0-20	Teeth 1 - 32, A - T	No	One restorative filling per tooth per restoration. Max number of surfaces to be reimbursed is 4.	
D2951	pin retention - per tooth, in addition to restoration	0-20	Teeth 1 - 32	No	One restorative filling per tooth per restoration. Max number of surfaces to be reimbursed is 4.	

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Exhibit A Benefits Covered for Amerigroup Children's Medicaid

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2954	prefabricated post and core in addition to crown	0-20	Teeth 1 - 32	No	One restorative filling per tooth per restoration. Max number of surfaces to be reimbursed is 4.	

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Exhibit A Benefits Covered for
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Endodontic services are provided to retain teeth through root canal therapy made necessary due to trauma or carious exposure.

The following guidelines must be followed when providing endodontic services:

Pulpotomies will only be covered on primary teeth with no evidence of internal resorption, furcation or periapical pathologic involvement.

The standard of acceptability employed for endodontic procedures requires that the canal(s) be completely filled apically and laterally. In cases where the root canal filling does not meet DentaQuest's treatment standards, DentaQuest can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Root canal therapy for permanent teeth includes diagnosis, extirpation of the pulp, shaping and enlarging the canals, temporary fillings, filling and obliteration of root canal(s), and progress radiographs. The fee does not include the final restoration.

Root canals and pulpotomies may not be covered in the following situations:

* Root resorption has started and exfoliation is imminent
* Gross periapical or periodontal pathosis is demonstrated radiographically (caries to the furcation, or subcrestal deeming the tooth non-restorable)
* The general oral condition does not justify root canal therapy due to the loss of arch integrity
* Tooth does not demonstrate 50% bone support
* Tooth demonstrates active untreated periodontal disease

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Endodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	0-20	Teeth 1 - 32, A - T	No	Not reimbursable when performed in conjunction with root canal therapy.	
D3221	pulpal debridement, primary and permanent teeth	0-20	Teeth 1 - 32, A - T	No		
D3310	endodontic therapy, anterior tooth (excluding final restoration)	2 - 20	Teeth 6 - 11, 22 - 27	No	One per Lifetime Per Tooth.	
D3320	endodontic therapy, premolar tooth (excluding final restoration)	2 - 20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	One per Lifetime Per Tooth.	

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Exhibit A Benefits Covered for
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Endodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3354	Pulpal regeneration includes completed regenerative trt of an immature perm tooth with a necrotic pulp. Includes removal of intracanal medication and procs necessary to regenerate cont'd root development and neccessary xrays.	0-20	Teeth 1 - 32	No		
D3410	apicoectomy - anterior	2 - 20	Teeth 6 - 11, 22 - 27	Yes	Not payable concurrently with root canal treatment of tooth.	
D3426	apicoectomy (each additional root)	0-20	Teeth 1 - 5, 12 - 21, 28 - 32	No		

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Periodontal scaling and root planing, gingivectomy, and certain other procedures as required can be considered for coverage. The initial stages of therapy should include Oral Hygiene Instructions and treatment to remove deposits. Surgical intervention will not be considered until there is a sufficient amount of time for healing and re-evaluation.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Periodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210) per 12 Month(s) Per patient per quadrant.	
D4240	gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4240) per 12 Month(s) Per patient per quadrant.	
D4260	osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4260) per 12 Month(s) Per patient per quadrant.	
D4270	pedicle soft tissue graft procedure	0-20	Teeth 1 - 32	Yes		
D4271	free soft tissue graft procedure	0-20	Teeth 1 - 32	Yes		
D4341	periodontal scaling and root planing - four or more teeth per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4341) per 1 Calendar year(s) Per patient per quadrant. One full mouth per patient per calendar year.	

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Provisions for removable prosthesis included initial placement when masticatory function is impaired or when existing prosthesis is at least five years old and unserviceable. All necessary restorative work must be completed before fabrication of a partial denture. Abutments for partial dentures must be free of active periodontal disease, and have at least 50% bone support.

Payment for dentures includes any necessary adjustments, repairs or relines necessary during the six - (6) month period following delivery of a new prosthesis. Relines are covered once every 24 months. The reimbursement for an incomplete denture service (non-delivery) will be limited to the out-of-pocket costs as documented by a copy of the lab bill. THE DATE OF PLACEMENT MUST BE USED AS THE DATE OF SERVICE WHEN SUBMITTING FOR PAYMENT OF DENTURES. Extractions and other procedures necessary prior to denture placement must be rendered and paid before dentures will be reimbursed. If immediate dentures, extractions must be rendered and billed with the same date of service as placement of the immediate dentures.

In situations where it is impractical to obtain pre-operative radiographs on a patient in a nursing home or long term care facility, a written narrative by the dentist stating that the patient is in a physical and mental state sufficient to function with full dentures is required for authorization.

Denture benefits for patients with the following medical conditions will not be considered for coverage:

* Patients on feeding tubes
* Post CVA patients with decreased facial muscle tone
* Patients in a coma
* Patients with diminished mental capacities that could not function with dentures
* Patients who do not desire dentures
* Advanced terminal patients

A partial denture that replaces only posterior permanent teeth must include three or more teeth on the dentures that are anatomically correct (natural size, shape, and color) to be compensable (excluding third molars). Partial dentures must include one anterior tooth and/or 3 posterior teeth (excluding third molars).

Fabrication of a removable prosthetic includes multiple steps(appointments) these multiple steps (impressions, try-in appointments, delivery etc.) are inclusive in the fee for the removable prosthetic and as such not eligible for additional compensation.

BILLING AND REIMBURSEMENT FOR CAST CROWNS, CAST POST & CORES AND LAMINATE VENEERS OR ANY OTHER FIXED PROSTHETICS SHALL BE BASED ON THE CEMENTATION DATE.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5110	complete denture - maxillary	0-20	Per Arch (01, UA)	Yes	One of (D5110) per 36 Month(s) Per patient.	
D5120	complete denture - mandibular	0-20	Per Arch (02, LA)	Yes	One of (D5120) per 36 Month(s) Per patient.	

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Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5130	immediate denture - maxillary	0-20	Per Arch (01, UA)	Yes	One of (D5130) per 1 Lifetime Per patient.	
D5140	immediate denture - mandibular	0-20	Per Arch (02, LA)	Yes	One of (D5140) per 1 Lifetime Per patient.	
D5211	maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	2 - 20		Yes	One of (D5211) per 36 Month(s) Per patient.	
D5212	mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	2 - 20		Yes	One of (D5212) per 36 Month(s) Per patient.	
D5410	adjust complete denture - maxillary	0-20		No	Two of (D5410) per 1 Year(s) Per patient.	
D5411	adjust complete denture - mandibular	0-20		No	Two of (D5411) per 1 Year(s) Per patient.	
D5421	adjust partial denture-maxillary	0-20		No	Two of (D5421) per 1 Year(s) Per patient.	
D5422	adjust partial denture - mandibular	0-20		No	Two of (D5422) per 1 Year(s) Per patient.	
D5511	repair broken complete denture base, mandibular	0-20		No	One of (D5511) per 12 Month(s) Per patient.	
D5512	repair broken complete denture base, maxillary	0-20		No	One of (D5512) per 12 Month(s) Per patient.	
D5640	replace broken teeth-per tooth	0-20	Teeth 1 - 32	No		
D5650	add tooth to existing partial denture	0-20	Teeth 1 - 32	No		
D5660	add clasp to existing partial denture	0-20		No		
D5750	reline complete maxillary denture (laboratory)	0-20		No	Two of (D5750) per 1 Year(s) Per patient.	
D5751	reline complete mandibular denture (laboratory)	0-20		No	Two of (D5751) per 1 Year(s) Per patient.	
D5850	tissue conditioning, maxillary	0-20		No	Two of (D5850) per 1 Year(s) Per patient.	
D5851	tissue conditioning,mandibular	0-20		No	Two of (D5851) per 1 Year(s) Per patient.	

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Provisions for removable prosthesis included initial placement when masticatory function is impaired or when existing prosthesis is at least five years old and unserviceable. All necessary restorative work must be completed before fabrication of a partial denture. Abutments for partial dentures must be free of active periodontal disease, and have at least 50% bone support.

Payment for dentures includes any necessary adjustments, repairs or relines necessary during the six - (6) month period following delivery of a new prosthesis. Relines are covered once every 24 months. The reimbursement for an incomplete denture service (non-delivery) will be limited to the out-of-pocket costs as documented by a copy of the lab bill. THE DATE OF PLACEMENT MUST BE USED AS THE DATE OF SERVICE WHEN SUBMITTING FOR PAYMENT OF DENTURES. Extractions and other procedures necessary prior to denture placement must be rendered and paid before dentures will be reimbursed. If immediate dentures, extractions must be rendered and billed with the same date of service as placement of the immediate dentures.

In situations where it is impractical to obtain pre-operative radiographs on a patient in a nursing home or long term care facility, a written narrative by the dentist stating that the patient is in a physical and mental state sufficient to function with full dentures is required for authorization.
Denture benefits for patients with the following medical conditions will not be considered for coverage:

* Patients on feeding tubes
* Post CVA patients with decreased facial muscle tone
* Patients in a coma
* Patients with diminished mental capacities that could not function with dentures
* Patients who do not desire dentures
* Advanced terminal patients

BILLING AND REIMBURSEMENT FOR CAST CROWNS, CAST POST & CORES AND LAMINATE VENEERS OR ANY OTHER FIXED PROSTHETICS SHALL BE BASED ON THE CEMENTATION DATE.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Maxillofacial Prosthetics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5992	Adjust maxillofacial prosthetic appliance, by report	0-20	Per Arch (01, 02, LA, UA)	No		
D5993	Maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral) other than required adjustments.	0-20	Per Arch (01, 02, LA, UA)	No		

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Fixed bridgework will only be considered for the replacement of the permanent anterior teeth.

Fixed Prosthetic Services are covered for Participants with prior authorization. Services will not be authorized until it is documented that all necessary restorative, endodontic, periodontic and oral surgery has been completed.

Fixed bridgework will not be allowed in conjunction with the placement of a partial denture in the same arch.

Fixed prosthesis will not be covered when they replace a removable appliance that is less than 5 years old.

The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent teeth.

BILLING AND REIMBURSEMENT FOR CAST CROWNS, CAST POST & CORES AND LAMINATE VENEERS OR ANY OTHER FIXED PROSTHETICS SHALL BE BASED ON THE CEMENTATION DATE.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Prosthodontics, fixed						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6254	Interim pontic-pontic used as an interim restoration for a duration of less than six months to allow adequate time for healing. This is not a temporaty pontic for routine prosthetic fixed partial denture restoration.	0-20	Teeth 1 - 32	No		

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Prophylactic removal of multiple asymptomatic teeth, or teeth free from pathology is not a covered benefit.

Extraction of deciduous teeth that radiographically appear to be near imminent exfoliation is not a covered benefit.

Reimbursement includes local anesthesia and post-operative care. Claims for all oral surgical procedures except simple non surgical extractions must include a pre-operative radiograph to be considered for reimbursement. General Dentists are required to submit authorizations and pre-operative radiographs for CDT code D7210 and higher.

Simple and surgical extractions are covered. Local anesthesia and routine post-operative care are included in the fees and will not be reimbursed separately.

“Erupted surgical extractions” are defined as extractions requiring elevation of a mucoperiosteal flap and removal of bone, and/or section of the tooth and closure.

Tuberosity reductions are not payable in conjunction with extractions or alveolectomy in the same quadrant.

For oral surgery performed as part of emergency care, the requirement for prior authorization is waived. Service will still be subject to retrospective review. Emergency care is defined as treatment of pain, infection, swelling, uncontrolled bleeding, or traumatic injury.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7111	extraction, coronal remnants - primary tooth	0-20	Teeth A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No limit. Prophylatic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No limit. Prophylatic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	0-20	Teeth 1 - 3, 14 - 19, 30 - 32, 51 - 53, 64 - 69, 80 - 82	Yes	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	0-20	Teeth 4 - 13, 20 - 29, 54 - 63, 70 - 79, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	
D7220	removal of impacted tooth-soft tissue	0-20	Teeth 1 - 32, 51 - 82	Yes		

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Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7230	removal of impacted tooth-partially bony	0-20	Teeth 1 - 32, 51 - 82	Yes		
D7240	removal of impacted tooth-completely bony	0-20	Teeth 1 - 32, 51 - 82	Yes		
D7250	surgical removal of residual tooth roots (cutting procedure)	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	No limit. Prophylatic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	
D7251	Coronectomy-intentional partial tooth removal is performed when a neurovascular complication is likely if the entire impacted tooth is removed.	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7260	oroantral fistula closure	0-20		Yes		
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	0-20	Teeth 1 - 32	Yes	Limited to one per accident regardless of the number of teeth involved and covers all needed services (i.e. splints, suturing, follow-up care).	
D7280	Surgical access of an unerupted tooth	2 - 20	Teeth 1 - 32	Yes	To expose crown of an impacted tooth not intended to be extracted.	
D7286	incisional biopsy of oral tissue-soft	0-20		Yes	For removal of arch itecturally intact specimen only. Not to be used with apicoectomy or periradicular curittage.	
D7295	Harvest of bone for use in autogenous grafting procedure	0-20		No		
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	2 - 20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One per lifetime per tooth.	
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	2 - 20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One per lifetime per tooth.	
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	2 - 20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One per lifetime per tooth.	

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Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	2 - 20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One per lifetime per tooth.	
D7440	excision of malignant tumor - lesion diameter up to 1.25cm	0-20		Yes		
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	0-20		Yes		
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm	0-20		Yes		
D7460	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm	0-20		Yes		
D7461	removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm	0-20		Yes		
D7471	removal of exostosis - per site	0-20	Per Arch (01, 02, LA, UA)	Yes		
D7510	incision and drainage of abscess - intraoral soft tissue	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes		
D7520	incision and drainage of abscess - extraoral soft tissue	0-20		Yes		
D7540	removal of reaction-producing foreign bodies, musculoskeletal system	0-20		Yes		
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes		
D7610	maxilla - open reduction	0-20		Yes	Fractures must be billed to include acrylic splints, any necessary wiring, office and post op visits, radiographs, and sutures.	
D7620	maxilla - closed reduction	0-20		Yes	Fractures must be billed to include acrylic splints, any necessary wiring, office and post op visits, radiographs, and sutures.	
D7630	mandible-open reduction	0-20		Yes	Fractures must be billed to include acrylic splints, any necessary wiring, office and post op visits, radiographs, and sutures.	

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Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7640	mandible - closed reduction	0-20		Yes	Fractures must be billed to include acrylic splints, any necessary wiring, office and post op visits, radiographs, and sutures.	
D7820	closed reduction dislocation	0-20		Yes	Must be billed to include office and post-op visits, radiographs, and sutures.	
D7910	suture small wounds up to 5 cm	0-20		Yes	Excludes closure of surgical icisions. Not to be used in conjunction with extractions.	
D7912	complex suture - greater than 5cm	0-20		Yes	Excludes closure of surgical icisions. Not to be used in conjunction with extractions.	
D7960	frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another procedure	2 - 20		Yes		
D7970	excision of hyperplastic tissue - per arch	0-20	Per Arch (01, 02, LA, UA)	Yes		
D7971	excision of pericoronal gingiva	0-20	Teeth 1 - 32	Yes		
D7997	appliance removal (not by dentist who placed appliance), includes removal of archbar	0-20		Yes	Not to be billed by dentist who placed appliance.	

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Exhibit A Benefits Covered for
Amerigroup Children's Medicaid

Participants between the ages of 2 and 20 may qualify for orthodontic care under the program. PARTICIPANTS MUST HAVE A SEVERE, DYSFUNCTIONAL, HANDICAPPING MALOCCLUSION OR OBJECTIVE DOCUMENTATION THAT THE MALOCCLUSION IS AN IMPAIRMENT OF, OR A HAZARD TO THE ABILITY TO EAT, CHEW, SPEAK, OR BREATHE. When it is determined that the case will not qualify for comprehensive orthodontic treatment, the initial examination (consultation) can be billed using procedure code D8999.

Since a case must be dysfunctional to be accepted for treatment, Participants whose molars and bicuspids are in good occlusion seldom qualify. INTERCEPTIVE ORTHODONTICS IS NOT A COVERED BENEFIT. Crowding alone is usually not dysfunctional in spite of the aesthetic considerations. The PARTICIPANT MUST HAVE LOST ALL PRIMARY TEETH AND HAVE PERMANENT TEETH ERUPTING OR IN OCCLUSION TO BE CONSIDERED.

All orthodontic services require prior authorization by a DentaQuest Consultant. Requests for prior authorization need to include:

* Orthodontic examination and records
* Appropriate radiographs and facial photographs
* Detailed treatment plan with diagnosis and prognosis

The fee for the initial exam, radiographs and study models should be submitted under procedure code D8660.

DentaQuest will reimburse doctors for orthodontic records when denial determinations are made. It is the responsibility of the rendering office to submit a claim for the payment of orthodontic records, as DentaQuest cannot generate claims on the behalf of its network doctors. Claims for orthodontic records payments must be: made in accordance with timely filing protocols, submitted on a HIPAA compliant ADA claim form, billed using CDT code D8660, and have history of a DentaQuest denied orthodontia request on file. As with all claims for payment, orthodontic records are subject to member eligibility, frequency, and benefit limitations outlined herein and in accordance with State regulations.

The starting and billing date of orthodontic services is defined as the date when the bands, brackets, or appliances are placed in the Participant's mouth. It is important to verify the Participant's eligibility, as the Participant must be eligible on this date of service.

Payment for orthodontics includes all appliances, retainers and all follow-up visits. Orthodontic appliance benefit limited to once per lifetime.

To initiate payment on an approved comprehensive orthodontic case, the dental office needs to submit a claim form indicating the date the appliances were placed (banding date). Monthly payments will be made for approved treatment as long as the Participant remains eligible and is in active treatment. IN ORDER TO RECEIVE REIMBURSEMENT FOR MONTHLY ADJUSTMENTS, PROVIDER MUST BILL FOR THE DATE OF SERVICE TREATMENT WAS RENDERED. A Participant will not be considered to be in active treatment if they have failed to keep appointments in two consecutive months. If a Participant fails to keep an appointment for two consecutive months, the dental office must notify DentaQuest.

Continuation of orthodontic care will be handled in the following fashion:

1.For cases started when the member was on Fee For Service Medicaid, DentaQuest will attempt to secure the original pre-treatment records for review by a DentaQuest Consultant. The original records will be reviewed using the criteria for all new cases. If the original records pass the test of medical necessity, a continuation of benefits based on a pro-rating of the treatment remaining will be paid.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

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Orthodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D8080	comprehensive orthodontic treatment of the adolescent dentition	2 - 20		Yes	One of (D8080) per 1 Lifetime Per patient.	
D8660	pre-orthodontic treatment examination to monitor growth and development	2 - 20		Yes	One of (D8660) per 6 Month(s) Per patient.	
D8670	periodic orthodontic treatment visit	2 - 20		Yes	One of (D8670) per 30 Day(s) Per patient.	

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Adjunctive general services include general anesthesia, intravenous sedation, nitrous oxide analgesia, consultations and various drugs and medicaments, and emergency services provided for relief of dental pain.

Procedure code D9110 – palliative treatment is to be used to bill for minor palliative procedures when the only other procedure code billed for is a diagnostic radiograph. If any other services (filling, endodontics, oral surgery etc.) are billed for on the same day, the palliative treatment code will be denied. Intravenous sedation and general anesthesia will only be a covered service for participating dentists that hold current certification and licensure per state and federal guidelines. Requests for intravenous sedation and general anesthesia will be reviewed on a case by case basis. A case will be covered for Participants with physical or mental health problems of such severity that treatment can not be reasonably attempted without the use of intravenous sedation or general anesthesia.

Intravenous sedation or general anesthesia may be allowed when a surgical procedure is being rendered. Claims for intravenous sedation and general anesthesia must include a narrative of medical necessity. Acceptable conditions include:

* Toxicity to local anesthesia supported by documentation;
* Severe mental retardation;
* Severe physical disability;
* Uncontrolled management problem;
* Extensive or complicated surgical procedures;
* Failure of local anesthesia;
* Documented medical complications; and
* Acute infection that would preclude the efficacy of local anesthesia.

For cases requiring intravenous sedation or general anesthesia, Providers must document the following in the Participant's chart for appropriate psychosomatic disorders: diagnosis, description of past evidence of situational anxiety or uncontrolledbehaviors, and in the case of referral due to uncontrolled behavior, the name of the referring dentist or provider group. Apprehension alone is not typically considered medically necessary. DentaQuest or the IDPA may elect to perform chart audits on these services. Services not documented as required may be denied for payment. The procedures will only be reimbursed for once per day regardless of the length of time it takes to complete the procedure.

General anesthesia, intravenous sedation, and nitrous oxide are only covered in conjunction with a covered dental procedure. Payment for any one of these services precludes payment for the remaining procedure codes. Payment for general anesthesia or intravenous sedation includes any other drugs administered on the same day.

Reimbursement for local anesthesia is included in the fee for the procedures.

Procedure code D9230 – nitrous oxide, is a covered service for Participants who are mentally or physically challenged, or otherwise present with special management needs. Special consideration is granted to individuals under the age of six that require extensive dental treatment and/or exhibit rampant caries where patient management is a concern.

Only claims for nitrous oxide with documented medical necessity will be considered for payment. Medical necessity for the use of nitrous oxide would be broadly defined as some condition. Some examples of conditions that would establish medical necessity for nitrous oxide are:

* Apprehensive child under the age of six when any treatment is rendered

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* Apprehensive children between 6 and 10 years of age when restorative or surgery is performed
* Apprehensive children between the ages of 10 and 18 years when surgical services are performed

All other situations for nitrous oxide will be reviewed for coverage on a case by case basis.

Procedure code D9310 – consultation, will only be reimbursed to a dentist other than the one providing definitive treatment. A consultation includes an examination and evaluation of the patient, and a written report from the consultant to the treating dentist. When billing for a consultation, a copy of the written report must be attached. When the consulting dentist also performs services reimbursement to that dentist will be limited to the actual services performed. There will not be a separate reimbursement for a consultation.

Procedure code D9999 is to be utilized to submit a request for reimbursement for a dental service not otherwise described herein. Request should include a description of the service, medical necessity, a proposed fee and any pertinent radiographs.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9110	palliative (emergency) treatment of dental pain - minor procedure	0-20		No		
D9222	deep sedation/general anesthesia – first 15 minutes	0-20		Yes	One of (D9222) per 1 Day(s) Per patient. Not allowed in conjunction with D9230, D9239, D9243, D9248 or D9920.	narrative of medical necessity
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment	0-20		Yes	Eight of (D9223) per 1 Day(s) Per patient.	
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	0-20		No		
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	0-20		Yes	One of (D9239) per 1 Day(s) Per patient.	narrative of medical necessity
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	0-20		Yes	Eight of (D9243) per 1 Day(s) Per patient.	
D9248	non-intravenous moderate (conscious) sedation	0-20		Yes		
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	0-20		Yes	Hospital Consultation Only. Should be billed in 30 minute increments. Limit of 6 D9310 per hospital admission.	
D9420	hospital or ambulatory surgical center call	0-20		Yes	Should be billed in 30 minute increments. Limit of 6 D9420 per hospital admission.	
D9440	office visit - after regularly scheduled hours	0-20		No	Two of (D9440) per 1 Year(s) Per patient.	

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Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9610	therapeutic drug injection, by report	0-20		Yes		
D9630	other drugs and/or medicaments, by report	0-20		Yes		
D9920	behavior management, by report	0-3		No	Sixteen of (D9920) per 1 Year(s) Per patient. To be billed in 15 minute increments. Allowed only for patients 3 years of age or younger, or are handicapped or special needs who cannot be managed or handled in the routine dental office setting through normal office procedures.	
D9920	behavior management, by report	4 - 20		Yes	Sixteen of (D9920) per 1 Year(s) Per patient. To be billed in 15 minute increments. Allowed only for patients 3 years of age or younger, or are handicapped or special needs who cannot be managed or handled in the routine dental office setting through normal office procedures.	

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Exhibit B Benefits Covered for Amerigroup PeachCare For Kids

Diagnostic services include the oral examinations, school based examinations and selected radiographs needed to assess the oral health, diagnose oral pathology and develop an adequate treatment plan for the Participant's oral health.

Reimbursement for radiographs includes exposure of the radiograph, developing, mounting and radiographic interpretation. Reimbursement for multiple radiographs of the same tooth or area may be denied if DentaQuest determines the number to be redundant, excessive or not in keeping with the federal policies relating to radiation exposure. DentaQuest utilizes the guidelines published by the Department of Health and uman Services, Center for Devices and Radiological Health. These guidelines were developed in conjunction with the Food and Drug Administration and are described in Attachment J of this manual.

If the total allowed amount for radiographs performed on a participant exceeds the allowed amount for procedure code D0210 (Complete Series), the submitted radiograph codes will be consolidated and paid as a Complete Series (D0210). The maximum reimbursement for a single date of service for radiographs shall be limited to the fee for a complete series.

A comprehensive oral evaluation (D0150) is typically used when evaluating a patient comprehensively. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. It may require interpretation of information acquired through additional diagnostic procedures. Additional diagnostic procedures should be reported separately.

This would include the evaluation and recording of the patient's dental and medical history and a general health assessment. It may typically include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, oral cancer screening, etc.

A periodic oral evaluation (D0120) is performed on a patient of record to determine any changes in the patient's dental and medical health status since a previous comprehensive or periodic evaluation. This may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately.

A complete Early Periodic Screening, Diagnosis and Treatment (EPSDT) school based examination is used when evaluating a patient comprehensively. It is a thorough evaluation and a recording of the extraoral and intraoral hard and soft tissues. This would include the evaluation and recording of the patient's dental and medical history and a general health assessment. It may typically include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, oral cancer screening, etc. if medically necessary to render D0150, D0210, D0272, D0274, D0330, or D1203 outside of established age parameters. Coverage Exception Request Form may be submitted prospectively for consideration (see Appendix- A 13)

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0120	periodic oral evaluation - established patient	0-20		No	One of (D0120, D0150) per 6 Month(s) Per patient. Either D0120 or D0150.	
D0140	limited oral evaluation-problem focused	0-20		No	Two of (D0140) per 1 Year(s) Per patient.	

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Exhibit B Benefits Covered for
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Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0150	comprehensive oral evaluation - new or established patient	0-20		No	One of (D0150) per 1 Lifetime Per Provider OR Location. One of (D0120, D0150) per 6 Month(s) Per patient.	
D0210	intraoral - complete series of radiographic images	6 - 20		No	One of (D0210) per 36 Month(s) Per patient. One of (D0210, D0330) per 36 Month(s) Per patient.	
D0220	intraoral - periapical first radiographic image	0-20		No		
D0230	intraoral - periapical each additional radiographic image	0-20		No		
D0240	intraoral - occlusal radiographic image	0-20		No		
D0270	bitewing - single radiographic image	0-20		No	One of (D0270, D0272, D0274) per 6 Month(s) Per patient.	
D0272	bitewings - two radiographic images	2 - 20		No	One of (D0270, D0272, D0274) per 6 Month(s) Per patient.	
D0274	bitewings - four radiographic images	10 - 20		No	One of (D0270, D0272, D0274) per 6 Month(s) Per patient.	
D0330	panoramic radiographic image	6 - 20		No	One of (D0330) per 36 Month(s) Per patient. One of (D0210, D0330) per 36 Month(s) Per patient.	

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Exhibit B Benefits Covered for
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Preventive services include routine and EPSDT prophylaxis (including scaling and polishing), topical fluoride treatments, dental sealants, and space maintenance therapy. The goal of providing routine and periodic preventive dental services is to maintain oral health and prevent more extensive dental procedures.

Routine prophylaxis is covered for Participants age 0 through 20, once per 6 months. Prophylaxis includes necessary scaling and polishing.

The topical application of fluoride treatment is allowed once per 6 months for Participants age 2 through 13.

Sealants are covered for Participants age 5 through 17. Sealants should be applied to the occlusal surfaces of all erupted and appropriate first and second permanent molars. Priority should be given to applying sealants for all 7 and 12 year olds. Sealants will not be covered when they are placed over restorations.

A lower lingual holding arch placed when there is not premature loss of a primary molar is considered a transitional orthodontic appliance and not a covered benefit.

PLACE OF SERVICE (field #38 on 2002, 2004 ADA claim form) MUST BE INDICATED ON ALL CLAIMS.

THE DATE OF PLACEMENT MUST BE USED AS THE DATE OF SERVICE WHEN SUBMITTING FOR PAYMENT OF SPACE MAINTAINERS.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Preventative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1110	prophylaxis - adult	14 - 20		No	One of (D1110) per 6 Month(s) Per patient. One of (D1110, D1120) per 6 Month(s) Per patient.	
D1120	prophylaxis - child	0-13		No	One of (D1120) per 6 Month(s) Per patient. One of (D1110, D1120) per 6 Month(s) Per patient. Removal of plaque, calculus and stains from the tooth surfaces. Intended to control local irrational factors.	
D1206	topical application of fluoride varnish	0-13		No	One of (D1203, D1206, D1208) per 6 Month(s) Per patient.	
D1208	topical application of fluoride - excluding varnish	0-20		No	One of (D1203, D1206, D1208) per 6 Month(s) Per patient. Prescription strength fluoride designed soley for use in the dental office, delivered to the dentition under the direct supervision of a dental professional.	

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Preventative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1351	sealant - per tooth	5-17	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	One of (D1351) per 4 Year(s) Per patient per tooth. Occlusal surfaces only. Teeth must be caries free. Sealant will not be covered when placed over restorations.	
D1510	space maintainer-fixed-unilateral	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	Covered when indicated due to premature loss of posterior primary teeth.	
D1515	space maintainer - fixed - bilateral	0-20	Per Arch (01, 02, LA, UA)	No	Covered when indicated due to premature loss of posterior primary teeth.	
D1525	space maintainer-removable-bilateral	0-20	Per Arch (01, 02, LA, UA)	No	Covered when indicated due to premature loss of posterior primary teeth.	
D1550	re-cement or re-bond space maintainer	0-20		No		

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Exhibit B Benefits Covered for
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Restorative services (amalgams and composites) are provided to remove decay and restore dental structures (teeth) to a reasonable condition. Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day.

When restorations involving multiple surfaces are requested or performed, that are outside the usual anatomical expectation, the allowance is limited to that of a one-surface restoration. Any fee charged in excess of the allowance for the one-surface restoration is DISALLOWED.

Bases, cements, liners, pulp caps, bonding agents and local anesthetic are included in the restorative service fees and are not reimbursed separately.

Generally, once a particular restoration is placed in a tooth, a similar restoration will not be covered for at least 12 months. Restorations are expected to last a reasonable amount of time. Repeated unexplained failures will result in review by Peer Review and may necessitate removal of the dentist from the panel.

The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent teeth.

BILLING AND REIMBURSEMENT FOR CAST CROWNS, CAST POST & CORES AND LAMINATE VENEERS OR ANY OTHER FIXED PROSTHETICS SHALL BE BASED ON THE CEMENTATION DATE.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2140	Amalgam - one surface, primary or permanent	0-20	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. One restorative filling per tooth per restoration. Max number of surfaces to be reimbursed is 4.	
D2150	Amalgam - two surfaces, primary or permanent	0-20	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. One restorative filling per tooth per restoration. Max number of surfaces to be reimbursed is 4.	
D2160	amalgam - three surfaces, primary or permanent	0-20	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. One restorative filling per tooth per restoration. Max number of surfaces to be reimbursed is 4.	

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Exhibit B Benefits Covered for Amerigroup PeachCare For Kids

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2161	amalgam - four or more surfaces, primary or permanent	0-20	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. One restorative filling per tooth per restoration. Max number of surfaces to be riembursed is 4.	
D2330	resin-based composite - one surface, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. One restorative filling per tooth per restoration. Max number of surfaces to be reimbursed is 4.	
D2331	resin-based composite - two surfaces, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. One restorative filling per tooth per restoration. Max number of surfaces to be reimbursed is 4.	
D2332	resin-based composite - three surfaces, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. One restorative filling per tooth per restoration. Max number of surfaces to be reimbursed is 4.	
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2391	resin-based composite - one surface, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. One restorative filling per tooth per restoration. Max number of surfaces to be reimbursed is 4.	

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Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2392	resin-based composite - two surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. One restorative filling per tooth per restoration. Max number of surfaces to be reimbursed is 4.	
D2393	resin-based composite - three surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2394	resin-based composite - four or more surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. One restorative filling per tooth per restoration. Max number of surfaces to be reimbursed is 4.	
D2920	re-cement or re-bond crown	0-20	Teeth 1 - 32, A - T	No		
D2930	prefabricated stainless steel crown - primary tooth	0-20	Teeth A - T	No	One of (D2930, D2934) per 1 Lifetime Per Provider OR Location per tooth.	
D2931	prefabricated stainless steel crown-permanent tooth	2 - 20	Teeth 1 - 32	No	One of (D2931) per 60 Month(s) Per Provider OR Location per tooth.	
D2932	prefabricated resin crown	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2932) per 60 Month(s) Per Provider OR Location per tooth.	
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	0-20	Teeth A - T	No	One of (D2930, D2934) per 1 Lifetime Per Provider OR Location per tooth. One restorative filling per tooth per restoration. Max number of surfaces to be reimbursed is 4	
D2940	protective restoration	0-20	Teeth 1 - 32, A - T	No		
D2951	pin retention - per tooth, in addition to restoration	0-20	Teeth 1 - 32	No		
D2954	prefabricated post and core in addition to crown	0-20	Teeth 1 - 32	No		

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Endodontic services are provided to retain teeth through root canal therapy made necessary due to trauma or carious exposure.

The following guidelines must be followed when providing endodontic services:

Pulpotomies will only be covered on primary teeth with no evidence of internal resorption, furcation or periapical pathologic involvement.

The standard of acceptability employed for endodontic procedures requires that the canal(s) be completely filled apically and laterally. In cases where the root canal filling does not meet DentaQuest's treatment standards, DentaQuest can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Root canal therapy for permanent teeth includes diagnosis, extirpation of the pulp, shaping and enlarging the canals, temporary fillings, filling and obliteration of root canal(s), and progress radiographs. The fee does not include the final restoration.

Root canals and pulpotomies may not be covered in the following situations:

* Root resorption has started and exfoliation is imminent
* Gross periapical or periodontal pathosis is demonstrated radiographically (caries to the furcation, or subcrestal deeming the tooth non-restorable)
* The general oral condition does not justify root canal therapy due to the loss of arch integrity
* Tooth does not demonstrate 50% bone support
* Tooth demonstrates active untreated periodontal disease

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Endodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	0-20	Teeth 1 - 32, A - T	No	Not reimbursable when performed in conjunction with root canal therapy.	
D3221	pulpal debridement, primary and permanent teeth	0-20	Teeth 1 - 32, A - T	No		
D3310	endodontic therapy, anterior tooth (excluding final restoration)	2 - 20	Teeth 6 - 11, 22 - 27	No	One per Lifetime Per Tooth.	
D3320	endodontic therapy, premolar tooth (excluding final restoration)	2 - 20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	One per Lifetime Per Tooth.	

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Endodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3354	Pulpal regeneration includes completed regenerative trt of an immature perm tooth with a necrotic pulp. Includes removal of intracanal medication and procs necessary to regenerate cont'd root development and neccessary xrays.	0-20	Teeth 1 - 32	No		
D3410	apicoectomy - anterior	2 - 20	Teeth 6 - 11, 22 - 27	Yes		
D3426	apicoectomy (each additional root)	0-20	Teeth 1 - 5, 12 - 21, 28 - 32	No		

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Periodontal scaling and root planing, gingivectomy, and certain other procedures as required can be considered for coverage. The initial stages of therapy should include Oral Hygiene Instructions and treatment to remove deposits. Surgical intervention will not be considered until there is a sufficient amount of time for healing and re-evaluation.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Periodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210) per 12 Month(s) Per patient per quadrant.	
D4240	gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4240) per 12 Month(s) Per patient per quadrant.	
D4260	osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4260) per 12 Month(s) Per patient per quadrant.	
D4270	pedicle soft tissue graft procedure	0-20	Teeth 1 - 32	Yes		
D4271	free soft tissue graft procedure	0-20	Teeth 1 - 32	Yes		
D4341	periodontal scaling and root planing - four or more teeth per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4341) per 1 Calendar year(s) Per patient per quadrant. One full mouth per patient per calendar year.	

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Provisions for removable prosthesis included initial placement when masticatory function is impaired or when existing prosthesis is at least five years old and unserviceable. All necessary restorative work must be completed before fabrication of a partial denture. Abutments for partial dentures must be free of active periodontal disease, and have at least 50% bone support.

Payment for dentures includes any necessary adjustments, repairs or relines necessary during the six - (6) month period following delivery of a new prosthesis. Relines are covered once every 24 months. The reimbursement for an incomplete denture service (non-delivery) will be limited to the out-of-pocket costs as documented by a copy of the lab bill. THE DATE OF PLACEMENT MUST BE USED AS THE DATE OF SERVICE WHEN SUBMITTING FOR PAYMENT OF DENTURES. Extractions and other procedures necessary prior to denture placement must be rendered and paid before dentures will be reimbursed. If immediate dentures, extractions must be rendered and billed with the same date of service as placement of the immediate dentures.

In situations where it is impractical to obtain pre-operative radiographs on a patient in a nursing home or long term care facility, a written narrative by the dentist stating that the patient is in a physical and mental state sufficient to function with full dentures is required for authorization.

Denture benefits for patients with the following medical conditions will not be considered for coverage:

* Patients on feeding tubes
* Post CVA patients with decreased facial muscle tone
* Patients in a coma
* Patients with diminished mental capacities that could not function with dentures
* Patients who do not desire dentures
* Advanced terminal patients

A partial denture that replaces only posterior permanent teeth must include three or more teeth on the dentures that are anatomically correct (natural size, shape, and color) to be compensable (excluding third molars). Partial dentures must include one anterior tooth and/or 3 posterior teeth (excluding third molars).

Fabrication of a removable prosthetic includes multiple steps(appointments) these multiple steps (impressions, try-in appointments, delivery etc.) are inclusive in the fee for the removable prosthetic and as such not eligible for additional compensation.

BILLING AND REIMBURSEMENT FOR CAST CROWNS, CAST POST & CORES AND LAMINATE VENEERS OR ANY OTHER FIXED PROSTHETICS SHALL BE BASED ON THE CEMENTATION DATE.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5110	complete denture - maxillary	0-20	Per Arch (01, UA)	Yes	One of (D5110) per 36 Month(s) Per patient.	
D5120	complete denture - mandibular	0-20	Per Arch (02, LA)	Yes	One of (D5120) per 36 Month(s) Per patient.	

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Exhibit B Benefits Covered for Amerigroup PeachCare For Kids

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5130	immediate denture - maxillary	0-20	Per Arch (01, UA)	Yes	One of (D5130) per 1 Lifetime Per patient.	
D5140	immediate denture - mandibular	0-20	Per Arch (02, LA)	Yes	One of (D5140) per 1 Lifetime Per patient.	
D5211	maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	2 - 20		Yes	One of (D5211) per 36 Month(s) Per patient.	
D5212	mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	2 - 20		Yes	One of (D5212) per 36 Month(s) Per patient.	
D5410	adjust complete denture - maxillary	0-20		No	Two of (D5410) per 1 Year(s) Per patient.	
D5411	adjust complete denture - mandibular	0-20		No	Two of (D5411) per 1 Year(s) Per patient.	
D5421	adjust partial denture-maxillary	0-20		No	Two of (D5421) per 1 Year(s) Per patient.	
D5422	adjust partial denture - mandibular	0-20		No	Two of (D5422) per 1 Year(s) Per patient.	
D5511	repair broken complete denture base, mandibular	0-20		No	One of (D5511) per 12 Month(s) Per patient.	
D5512	repair broken complete denture base, maxillary	0-20		No	One of (D5512) per 12 Month(s) Per patient.	
D5640	replace broken teeth-per tooth	0-20	Teeth 1 - 32	No		
D5650	add tooth to existing partial denture	0-20	Teeth 1 - 32	No		
D5660	add clasp to existing partial denture	0-20		No		
D5750	reline complete maxillary denture (laboratory)	0-20		No	Two of (D5750) per 1 Year(s) Per patient.	
D5751	reline complete mandibular denture (laboratory)	0-20		No	Two of (D5751) per 1 Year(s) Per patient.	
D5850	tissue conditioning, maxillary	0-20		No	Two of (D5850) per 1 Year(s) Per patient.	
D5851	tissue conditioning,mandibular	0-20		No	Two of (D5851) per 1 Year(s) Per patient.	

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Provisions for removable prosthesis included initial placement when masticatory function is impaired or when existing prosthesis is at least five years old and unserviceable. All necessary restorative work must be completed before fabrication of a partial denture. Abutments for partial dentures must be free of active periodontal disease, and have at least 50% bone support.

Payment for dentures includes any necessary adjustments, repairs or relines necessary during the six - (6) month period following delivery of a new prosthesis. Relines are covered once every 24 months. The reimbursement for an incomplete denture service (non-delivery) will be limited to the out-of-pocket costs as documented by a copy of the lab bill. THE DATE OF PLACEMENT MUST BE USED AS THE DATE OF SERVICE WHEN SUBMITTING FOR PAYMENT OF DENTURES. Extractions and other procedures necessary prior to denture placement must be rendered and paid before dentures will be reimbursed. If immediate dentures, extractions must be rendered and billed with the same date of service as placement of the immediate dentures.

In situations where it is impractical to obtain pre-operative radiographs on a patient in a nursing home or long term care facility, a written narrative by the dentist stating that the patient is in a physical and mental state sufficient to function with full dentures is required for authorization.
Denture benefits for patients with the following medical conditions will not be considered for coverage:

* Patients on feeding tubes
* Post CVA patients with decreased facial muscle tone
* Patients in a coma
* Patients with diminished mental capacities that could not function with dentures
* Patients who do not desire dentures
* Advanced terminal patients

BILLING AND REIMBURSEMENT FOR CAST CROWNS, CAST POST & CORES AND LAMINATE VENEERS OR ANY OTHER FIXED PROSTHETICS SHALL BE BASED ON THE CEMENTATION DATE.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Maxillofacial Prosthetics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5992	Adjust maxillofacial prosthetic appliance, by report	0-20	Per Arch (01, 02, LA, UA)	No		
D5993	Maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral) other than required adjustments.	0-20	Per Arch (01, 02, LA, UA)	No		

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Fixed bridgework will only be considered for the replacement of the permanent anterior teeth.

Fixed Prosthetic Services are covered for Participants with prior authorization. Services will not be authorized until it is documented that all necessary restorative, endodontic, periodontic and oral surgery has been completed.

Fixed bridgework will not be allowed in conjunction with the placement of a partial denture in the same arch.

Fixed prosthesis will not be covered when they replace a removable appliance that is less than 5 years old.

The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent teeth.

BILLING AND REIMBURSEMENT FOR CAST CROWNS, CAST POST & CORES AND LAMINATE VENEERS OR ANY OTHER FIXED PROSTHETICS SHALL BE BASED ON THE CEMENTATION DATE.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Prosthodontics, fixed						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6254	Interim pontic-pontic used as an interim restoration for a duration of less than six months to allow adequate time for healing. This is not a temporaty pontic for routine prosthetic fixed partial denture restoration.	0-20	Teeth 1 - 32	No		

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Prophylactic removal of multiple asymptomatic teeth, or teeth free from pathology is not a covered benefit.

Extraction of deciduous teeth that radiographically appear to be near imminent exfoliation is not a covered benefit.

Reimbursement includes local anesthesia and post-operative care. Claims for all oral surgical procedures except simple non surgical extractions must include a pre-operative radiograph to be considered for reimbursement. General Dentists are required to submit authorizations and pre-operative radiographs for CDT code D7210 and higher.

Simple and surgical extractions are covered. Local anesthesia and routine post-operative care are included in the fees and will not be reimbursed separately.

"Erupted surgical extractions" are defined as extractions requiring elevation of a mucoperiosteal flap and removal of bone, and/or section of the tooth and closure.

Tuberosity reductions are not payable in conjunction with extractions or alveolectomy in the same quadrant.

For oral surgery performed as part of emergency care, the requirement for prior authorization is waived. Service will still be subject to retrospective review. Emergency care is defined as treatment of pain, infection, swelling, uncontrolled bleeding, or traumatic injury.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7111	extraction, coronal remnants - primary tooth	0-20	Teeth A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No limit. Prophylatic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No limit. Prophylatic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	0-20	Teeth 1 - 3, 14 - 19, 30 - 32, 51 - 53, 64 - 69, 80 - 82	Yes	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	0-20	Teeth 4 - 13, 20 - 29, 54 - 63, 70 - 79, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	
D7220	removal of impacted tooth-soft tissue	0-20	Teeth 1 - 32, 51 - 82	Yes		

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Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7230	removal of impacted tooth-partially bony	0-20	Teeth 1 - 32, 51 - 82	Yes		
D7240	removal of impacted tooth-completely bony	0-20	Teeth 1 - 32, 51 - 82	Yes		
D7250	surgical removal of residual tooth roots (cutting procedure)	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes		
D7251	Coronectomy-intentional partial tooth removal is performed when a neurovascular complication is likely if the entire impacted tooth is removed.	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7260	oroantral fistula closure	0-20		Yes		
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	0-20	Teeth 1 - 32	Yes	Limited to one per accident regardless of the number of teeth involved and covers all needed services (i.e. splints, suturing, follow-up care).	
D7280	Surgical access of an unerupted tooth	2 - 20	Teeth 1 - 32	Yes	To expose crown of an impacted tooth not intended to be extracted.	
D7286	incisional biopsy of oral tissue-soft	0-20		Yes	For removal of arch itecturally intact specimen only. Not to be used with apicoectomy or periradicular curittage.	
D7295	Harvest of bone for use in autogenous grafting procedure	0-20		No		
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	2 - 20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One per lifetime per tooth.	
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	2 - 20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One per lifetime per tooth.	
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	2 - 20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One per lifetime per tooth.	

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Exhibit B Benefits Covered for Amerigroup PeachCare For Kids

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	2 - 20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One per lifetime per tooth.	
D7440	excision of malignant tumor - lesion diameter up to 1.25cm	0-20		Yes		
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	0-20		Yes		
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm	0-20		Yes		
D7460	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm	0-20		Yes		
D7461	removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm	0-20		Yes		
D7471	removal of exostosis - per site	0-20	Per Arch (01, 02, LA, UA)	Yes		
D7510	incision and drainage of abscess - intraoral soft tissue	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes		
D7520	incision and drainage of abscess - extraoral soft tissue	0-20		Yes		
D7540	removal of reaction-producing foreign bodies, musculoskeletal system	0-20		Yes		
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes		
D7610	maxilla - open reduction	0-20		Yes	Fractures must be billed to include acrylic splints, any necessary wiring, office and post op visits, radiographs, and sutures.	
D7620	maxilla - closed reduction	0-20		Yes	Fractures must be billed to include acrylic splints, any necessary wiring, office and post op visits, radiographs, and sutures.	
D7630	mandible-open reduction	0-20		Yes	Fractures must be billed to include acrylic splints, any necessary wiring, office and post op visits, radiographs, and sutures.	

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Exhibit B Benefits Covered for Amerigroup PeachCare For Kids

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7640	mandible - closed reduction	0-20		Yes	Fractures must be billed to include acrylic splints, any necessary wiring, office and post op visits, radiographs, and sutures.	
D7820	closed reduction dislocation	0-20		Yes	Must be billed to include office and post-op visits, radiographs, and sutures.	
D7910	suture small wounds up to 5 cm	0-20		Yes	Excludes closure of surgical icisions. Not to be used in conjunction with extractions.	
D7912	complex suture - greater than 5cm	0-20		Yes	Excludes closure of surgical icisions. Not to be used in conjunction with extractions.	
D7960	frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another procedure	2 - 20		Yes		
D7970	excision of hyperplastic tissue - per arch	0-20	Per Arch (01, 02, LA, UA)	Yes		
D7971	excision of pericoronal gingiva	0-20	Teeth 1 - 32	Yes		
D7997	appliance removal (not by dentist who placed appliance), includes removal of archbar	0-20		Yes	Not to be billed by dentist who placed appliance.	

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Exhibit B Benefits Covered for
Amerigroup PeachCare For Kids

Participants between the ages of 2 and 20 may qualify for orthodontic care under the program. PARTICIPANTS MUST HAVE A SEVERE, DYSFUNCTIONAL, HANDICAPPING MALOCCLUSION OR OBJECTIVE DOCUMENTATION THAT THE MALOCCLUSION IS AN IMPAIRMENT OF, OR A HAZARD TO THE ABILITY TO EAT, CHEW, SPEAK, OR BREATHE. When it is determined that the case will not qualify for comprehensive orthodontic treatment, the initial examination (consultation) can be billed using procedure code D8999.

Since a case must be dysfunctional to be accepted for treatment, Participants whose molars and bicuspids are in good occlusion seldom qualify. INTERCEPTIVE ORTHODONTICS IS NOT A COVERED BENEFIT. Crowding alone is usually not dysfunctional in spite of the aesthetic considerations. The PARTICIPANT MUST HAVE LOST ALL PRIMARY TEETH AND HAVE PERMANENT TEETH ERUPTING OR IN OCCLUSION TO BE CONSIDERED.

All orthodontic services require prior authorization by a DentaQuest Consultant. Requests for prior authorization need to include:
* Orthodontic examination and records
* Appropriate radiographs and facial photographs
* Detailed treatment plan with diagnosis and prognosis

The fee for the initial exam, radiographs and study models should be submitted under procedure code D8660.

DentaQuest will reimburse doctors for orthodontic records when denial determinations are made. It is the responsibility of the rendering office to submit a claim for the payment of orthodontic records, as DentaQuest cannot generate claims on the behalf of its network doctors. Claims for orthodontic records payments must be: made in accordance with timely filing protocols, submitted on a HIPAA compliant ADA claim form, billed using CDT code D8660, and have history of a DentaQuest denied orthodontia request on file. As with all claims for payment, orthodontic records are subject to member eligibility, frequency, and benefit limitations outlined herein and in accordance with State regulations.

The starting and billing date of orthodontic services is defined as the date when the bands, brackets, or appliances are placed in the Participant’s mouth. It is important to verify the Participant’s eligibility, as the Participant must be eligible on this date of service.

Payment for orthodontics includes all appliances, retainers and all follow-up visits. Orthodontic appliance benefit limited to once per lifetime.

To initiate payment on an approved comprehensive orthodontic case, the dental office needs to submit a claim form indicating the date the appliances were placed (banding date). Monthly payments will be made for approved treatment as long as the Participant remains eligible and is in active treatment. IN ORDER TO RECEIVE REIMBURSEMENT FOR MONTHLY ADJUSTMENTS, PROVIDER MUST BILL FOR THE DATE OF SERVICE TREATMENT WAS RENDERED. A Participant will not be considered to be in active treatment if they have failed to keep appointments in two consecutive months. If a Participant fails to keep an appointment for two consecutive months, the dental office must notify DentaQuest.

Continuation of orthodontic care will be handled in the following fashion:

1.For cases started when the member was on Fee For Service Medicaid, DentaQuest will attempt to secure the original pre-treatment records for review by a DentaQuest Consultant. The original records will be reviewed using the criteria for all new cases. If the original records pass the test of medical necessity, a continuation of benefits based on a pro-rating of the treatment remaining will be paid.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

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Orthodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D8080	comprehensive orthodontic treatment of the adolescent dentition	2 - 20		Yes	One of (D8080) per 1 Lifetime Per patient.	
D8660	pre-orthodontic treatment examination to monitor growth and development	2 - 20		Yes	One of (D8660) per 6 Month(s) Per patient.	
D8670	periodic orthodontic treatment visit	2 - 20		Yes	One of (D8670) per 21 Day(s) Per patient.	

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Adjunctive general services include general anesthesia, intravenous sedation, nitrous oxide analgesia, consultations and various drugs and medicaments, and emergency services provided for relief of dental pain.

Procedure code D9110 – palliative treatment is to be used to bill for minor palliative procedures when the only other procedure code billed for is a diagnostic radiograph. If any other services (filling, endodontics, oral surgery etc.) are billed for on the same day, the palliative treatment code will be denied. Intravenous sedation and general anesthesia will only be a covered service for participating dentists that hold current certification and licensure per state and federal guidelines. Requests for intravenous sedation and general anesthesia will be reviewed on a case by case basis. A case will be covered for Participants with physical or mental health problems of such severity that treatment can not be reasonably attempted without the use of intravenous sedation or general anesthesia.

Intravenous sedation or general anesthesia may be allowed when a surgical procedure is being rendered. Claims for intravenous sedation and general anesthesia must include a narrative of medical necessity. Acceptable conditions include:

* Toxicity to local anesthesia supported by documentation;
* Severe mental retardation;
* Severe physical disability;
* Uncontrolled management problem;
* Extensive or complicated surgical procedures;
* Failure of local anesthesia;
* Documented medical complications; and
* Acute infection that would preclude the efficacy of local anesthesia.

For cases requiring intravenous sedation or general anesthesia, Providers must document the following in the Participant's chart for appropriate psychosomatic disorders: diagnosis, description of past evidence of situational anxiety or uncontrolledbehaviors, and in the case of referral due to uncontrolled behavior, the name of the referring dentist or provider group. Apprehension alone is not typically considered medically necessary. DentaQuest or the IDPA may elect to perform chart audits on these services. Services not documented as required may be denied for payment. The procedures will only be reimbursed for once per day regardless of the length of time it takes to complete the procedure.

General anesthesia, intravenous sedation, and nitrous oxide are only covered in conjunction with a covered dental procedure. Payment for any one of these services precludes payment for the remaining procedure codes. Payment for general anesthesia or intravenous sedation includes any other drugs administered on the same day.

Reimbursement for local anesthesia is included in the fee for the procedures.

Procedure code D9230 – nitrous oxide, is a covered service for Participants who are mentally or physically challenged, or otherwise present with special management needs. Special consideration is granted to individuals under the age of six that require extensive dental treatment and/or exhibit rampant caries where patient management is a concern.

Only claims for nitrous oxide with documented medical necessity will be considered for payment. Medical necessity for the use of nitrous oxide would be broadly defined as some condition. Some examples of conditions that would establish medical necessity for nitrous oxide are:

* Apprehensive child under the age of six when any treatment is rendered

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* Apprehensive children between 6 and 10 years of age when restorative or surgery is performed
* Apprehensive children between the ages of 10 and 18 years when surgical services are performed

All other situations for nitrous oxide will be reviewed for coverage on a case by case basis.

Procedure code D9310 – consultation, will only be reimbursed to a dentist other than the one providing definitive treatment. A consultation includes an examination and evaluation of the patient, and a written report from the consultant to the treating dentist. When billing for a consultation, a copy of the written report must be attached. When the consulting dentist also performs services reimbursement to that dentist will be limited to the actual services performed. There will not be a separate reimbursement for a consultation.

Procedure code D9999 is to be utilized to submit a request for reimbursement for a dental service not otherwise described herein. Request should include a description of the service, medical necessity, a proposed fee and any pertinent radiographs.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9110	palliative (emergency) treatment of dental pain - minor procedure	0-20		No		
D9222	deep sedation/general anesthesia – first 15 minutes	0-20		Yes	One of (D9222) per 1 Day(s) Per patient. Not allowed in conjunction with D9230, D9239, D9243, D9248 or D9920.	narrative of medical necessity
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment	0-20		Yes	Eight of (D9223) per 1 Day(s) Per patient.	
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	0-20		No		
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	0-20		Yes	One of (D9239) per 1 Day(s) Per patient.	narrative of medical necessity
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	0-20		Yes	Eight of (D9243) per 1 Day(s) Per patient.	
D9248	non-intravenous moderate (conscious) sedation	0-20		Yes		
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	0-20		Yes	Hospital Consultation Only. Should be billed in 30 minute increments. Limit of 6 D9310 per hospital admission.	
D9420	hospital or ambulatory surgical center call	0-20		Yes	Should be billed in 30 minute increments. Limit of 6 D9420 per hospital admission.	
D9440	office visit - after regularly scheduled hours	0-20		No	Two of (D9440) per 1 Year(s) Per patient.	

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Exhibit B Benefits Covered for Amerigroup PeachCare For Kids

Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9610	therapeutic drug injection, by report	0-20		Yes		
D9630	other drugs and/or medicaments, by report	0-20		Yes		
D9920	behavior management, by report	0-3		No	Sixteen of (D9920) per 1 Year(s) Per patient. To be billed in 15 minute increments. Allowed only for patients 3 years of age or younger, or are handicapped or special needs who cannot be managed or handled in the routine dental office setting through normal office procedures.	
D9920	behavior management, by report	4 - 20		Yes	Sixteen of (D9920) per 1 Year(s) Per patient. To be billed in 15 minute increments. Allowed only for patients 3 years of age or younger, or are handicapped or special needs who cannot be managed or handled in the routine dental office setting through normal office procedures.	

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Exhibit C Benefits Covered for Amerigroup Adult Medicaid

Diagnostic services include the oral examinations and selected radiographs needed to assess the oral health, diagnose oral pathology and develop an adequate treatment plan for the Participant's oral health.

Reimbursement for radiographs includes exposure of the radiograph, developing, mounting and radiographic interpretation. Reimbursement for multiple radiographs of the same tooth or area may be denied if DentaQuest determines the number to be redundant, excessive or not in keeping with the federal policies relating to radiation exposure. DentaQuest utilizes the guidelines published by the Department of Health and Human Services, Center for Devices and Radiological Health. These guidelines were developed in conjunction with the Food and Drug Administration and are described in Attachment J of this manual.

An initial examination is typically used when evaluating a patient comprehensively. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. It may require interpretation of information acquired through additional diagnostic procedures. Additional diagnostic procedures should be reported separately.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0120	periodic oral evaluation - established patient	21 and older		No	One of (D0120) per 6 Month(s) Per patient.	
D0140	limited oral evaluation-problem focused	21 and older		No	Two of (D0140) per 1 Year(s) Per Provider OR Location.	
D0150	comprehensive oral evaluation - new or established patient	21 and older		No	One of (D0150) per 1 Lifetime Per Provider OR Location.	
D0220	intraoral - periapical first radiographic image	21 and older		No	One of (D0220) per 1 Day(s) Per patient.	
D0230	intraoral - periapical each additional radiographic image	21 and older		No		
D0270	bitewing - single radiographic image	21 and older		No	One of (D0270) per 6 Month(s) Per patient.	
D0272	bitewings - two radiographic images	21 and older		No	One of (D0272) per 6 Month(s) Per patient.	
D0274	bitewings - four radiographic images	21 and older		No	One of (D0274) per 6 Month(s) Per patient.	
D0330	panoramic radiographic image	21 and older		No	One of (D0330) per 36 Month(s) Per patient.	

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Exhibit C Benefits Covered for
Amerigroup Adult Medicaid

Preventive services include routine prophylaxis (including scaling and polishing) for Participants over age 21. The goal of providing routine and periodic preventive dental services is to maintain oral health and prevent more extensive dental procedures.

Routine prophylaxis is covered for Participants over age 21, once every 6 months. Prophylaxis includes necessary scaling and polishing.

A lower lingual holding arch placed when there is not premature loss of a primary molar is considered a transitional orthodontic appliance and not a covered benefit. PLACE OF SERVICE (field #38 on 2002, 2004 ADA claim form) MUST BE INDICATED ON ALL CLAIMS.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Preventative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1110	prophylaxis - adult	21 and older		No	One of (D1110) per 6 Month(s) Per patient. Includes scaling and polishing procedures to remove coronal plaque, calculus and stains	

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Exhibit C Benefits Covered for
Amerigroup Adult Medicaid

Endodontic services are provided to retain teeth through root canal therapy made necessary due to trauma or carious exposure.

The following guidelines must be followed when providing endodontic services:

Pulpotomies will only be covered on primary teeth with no evidence of internal resorption, furcation or periapical pathologic involvement.

The standard of acceptability employed for endodontic procedures requires that the canal(s) be completely filled apically and laterally. In cases where the root canal filling does not meet DentaQuest's treatment standards, DentaQuest can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Root canal therapy for permanent teeth includes diagnosis, extirpation of the pulp, shaping and enlarging the canals, temporary fillings, filling and obliteration of root canal(s), and progress radiographs. The fee does not include the final restoration.

Root canals and pulpotomies may not be covered in the following situations:

* Root resorption has started and exfoliation is imminent
* Gross periapical or periodontal pathosis is demonstrated radiographically (caries to the furcation, or subcrestal deeming the tooth non-restorable)
* The general oral condition does not justify root canal therapy due to the loss of arch integrity
* Tooth does not demonstrate 50% bone support
* Tooth demonstrates active untreated periodontal disease

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Endodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3354	Pulpal regeneration includes completed regenerative trt of an immature perm tooth with a necrotic pulp. Includes removal of intracanal medication and procs necessary to regenerate cont'd root development and neccessary xrays.	21 and older	Teeth 1 - 32	No		

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Exhibit C Benefits Covered for
Amerigroup Adult Medicaid

BILLING AND REIMBURSEMENT FOR CAST CROWNS, CAST POST & CORES AND LAMINATE VENEERS OR ANY OTHER FIXED PROSTHETICS SHALL BE BASED ON THE CEMENTATION DATE.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Maxillofacial Prosthetics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5992	Adjust maxillofacial prosthetic appliance, by report	21 and older	Per Arch (01, 02, LA, UA)	No		
D5993	Maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral) other than required adjustments.	21 and older	Per Arch (01, 02, LA, UA)	No		

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The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent teeth.
BILLING AND REIMBURSEMENT FOR CAST CROWNS, CAST POST & CORES AND LAMINATE VENEERS OR ANY OTHER FIXED PROSTHETICS SHALL BE BASED ON THE CEMENTATION DATE.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Prosthodontics, fixed						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6254	Interim pontic-pontic used as an interim restoration for a duration of less than six months to allow adequate time for healing. This is not a temporaty pontic for routine prosthetic fixed partial denture restoration.	21 and older	Teeth 1 - 32	No		

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Prophylactic removal of multiple asymptomatic teeth, or teeth free from pathology is not a covered benefit.

Extraction of deciduous teeth that radiographically appear to be near imminent exfoliation is not a covered benefit.

Reimbursement includes local anesthesia and post-operative care.

Claims for all oral surgical procedures except simple non surgical extractions must include a pre-operative radiograph to be considered for reimbursement. General Dentists are required to submit authorizations and pre-operative radiographs for CDT code D7210 and higher.

Simple and surgical extractions are covered. Local anesthesia and routine post-operative care are included in the fees and will not be reimbursed separately.

“Erupted surgical extractions” are defined as extractions requiring elevation of a mucoperiosteal flap and removal of bone, and/or section of the tooth and closure.

Tuberosity reductions are not payable in conjunction with extractions or alveolectomy in the same quadrant. For oral surgery performed as part of emergency care, the requirement for prior authorization is waived. Service will still be subject to retrospective review. Emergency care is defined as treatment of pain, infection, swelling, uncontrolled bleeding, or traumatic injury.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7111	extraction, coronal remnants - primary tooth	21 and older	Teeth A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	21 and older	Teeth 1 - 3, 14 - 19, 30 - 32, 51 - 53, 64 - 69, 80 - 82	Yes	Prophylatic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	21 and older	Teeth 4 - 13, 20 - 29, 54 - 63, 70 - 79, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Prophylatic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	

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Exhibit C Benefits Covered for Amerigroup Adult Medicaid

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7220	removal of impacted tooth-soft tissue	21 and older	Teeth 1 - 32, 51 - 82	Yes	Prophylatic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	
D7230	removal of impacted tooth-partially bony	21 and older	Teeth 1 - 32, 51 - 82	Yes	Prophylatic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	
D7240	removal of impacted tooth-completely bony	21 and older	Teeth 1 - 32, 51 - 82	Yes	Prophylatic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	
D7250	surgical removal of residual tooth roots (cutting procedure)	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Prophylatic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit. Not reimbursable to the provider performing the extraction.	
D7251	Coronectomy-intentional partial tooth removal is performed when a neurovascular complication is likely if the entire impacted tooth is removed.	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	21 and older	Teeth 1 - 32	Yes	Limited to one per accident regardless of the number of teeth involved and covers all needed services (i.e. splints, suturing, follow-up care).	
D7286	incisional biopsy of oral tissue-soft	21 and older		Yes	For removal of architechturary intact specimen only. Not to be used with apicoectomy or periradicular curittage.	
D7295	Harvest of bone for use in autogenous grafting procedure	21 and older		No		
D7510	incision and drainage of abscess - intraoral soft tissue	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Either D7510 or D7511 on date of service.	
D7520	incision and drainage of abscess - extraoral soft tissue	21 and older		Yes	Either D7520 or D7521 on date of service.	
D7540	removal of reaction-producing foreign bodies, musculoskeletal system	21 and older		Yes		

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Exhibit C Benefits Covered for Amerigroup Adult Medicaid

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7610	maxilla - open reduction	21 and older		Yes	Fractures must be billed to include acrylic splints, and necessary wiring, office and post-op visitis, radiographs, and suturing..	
D7620	maxilla - closed reduction	21 and older		Yes	Fractures must be billed to include acrylic splints, and necessary wiring, office and post-op visitis, radiographs, and suturing.	
D7630	mandible-open reduction	21 and older		Yes	Fractures must be billed to include acrylic splints, and necessary wiring, office and post-op visitis, radiographs, and suturing.	
D7640	mandible - closed reduction	21 and older		Yes	Fractures must be billed to include acrylic splints, and necessary wiring, office and post-op visitis, radiographs, and suturing.	
D7820	closed reduction dislocation	21 and older		Yes	Must be billed to include office and post-op visits, radiographs, and suturing.	
D7910	suture small wounds up to 5 cm	21 and older		Yes	Excludes closure of surgical incisions. Not to be used in conjunction with extractions.	
D7912	complex suture - greater than 5cm	21 and older		Yes	Excludes closure of surgical incisions. Not to be used in conjunction with extractions.	

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Adjunctive general services include general anesthesia, intravenous sedation, nitrous oxide analgesia, consultations and various drugs and medicaments, and emergency services provided for relief of dental pain.

Intravenous sedation and general anesthesia will only be a covered service for participating dentists that hold current certification and licensure per state and federal guidelines.

Requests for intravenous sedation and general anesthesia will be reviewed on a case by case basis. A case will be covered for Participants with physical or mental health problems of such severity that treatment can not be reasonably attempted without the use of intravenous sedation or general anesthesia. Intravenous sedation or general anesthesia may be allowed when a surgical procedure is being rendered. Claims for intravenous sedation and general anesthesia must include a narrative of medical necessity. Acceptable conditions include:

* Toxicity to local anesthesia supported by documentation;
* Severe mental retardation;
* Severe physical disability;
* Uncontrolled management problem;
* Extensive or complicated surgical procedures;
* Failure of local anesthesia;
* Documented medical complications; and
* Acute infection that would preclude the efficacy of local anesthesia.

For cases requiring intravenous sedation or general anesthesia, Providers must document the following in the Participant's chart for appropriate psychosomatic disorders: diagnosis, description of past evidence of situational anxiety or uncontrolledbehaviors, and in the case of referral due to uncontrolled behavior, the name of the referring dentist or provider group. Apprehension alone is not typically considered medically necessary. DentaQuest may elect to perform chart audits on these services. Services not documented as required may be denied for payment. The procedures will only be reimbursed for once per day regardless of the length of time it takes to complete the procedure.

General anesthesia, intravenous sedation, and nitrous oxide are only covered in conjunction with a covered dental procedure. Payment for any one of these services precludes payment for the remaining procedure codes. Payment for general anesthesia or intravenous sedation includes any other drugs administered on the same day.

Reimbursement for local anesthesia is included in the fee for the procedures.

Procedure code D9230 – nitrous oxide, is a covered service for Participants who are mentally or physically challenged, or otherwise present with special management needs.

Only claims for nitrous oxide with documented medical necessity will be considered for payment. Medical necessity for the use of nitrous oxide would be broadly defined as some condition specific to the particular treatment situation that would preclude the performance of necessary dental treatment, with the use of a local anesthetic alone. Situations for nitrous oxide will be reviewed for coverage on a case by case basis.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

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Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9222	deep sedation/general anesthesia – first 15 minutes	21 and older		Yes	One of (D9222) per 1 Day(s) Per patient. Not allowed in conjunction with D9230, D9239, D9243, D9248 or D9920.	narrative of medical necessity
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment	21 and older		Yes	Eight of (D9223) per 1 Day(s) Per patient.	
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	21 and older		No		
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	21 and older		Yes	One of (D9239) per 1 Day(s) Per patient.	narrative of medical necessity
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	21 and older		Yes	Eight of (D9243) per 1 Day(s) Per patient.	
D9248	non-intravenous moderate (conscious) sedation	21 and older		Yes		
D9440	office visit - after regularly scheduled hours	21 and older		No	Two of (D9440) per 1 Year(s) Per patient.	

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Exhibit D Benefits Covered for
Amerigroup Medicaid Pregnant Women

Diagnostic services include the oral examinations and selected radiographs needed to assess the oral health, diagnose oral pathology and develop an adequate treatment plan for the Participant's oral health.

Reimbursement for radiographs includes exposure of the radiograph, developing, mounting and radiographic interpretation. Reimbursement for multiple radiographs of the same tooth or area may be denied if DentaQuest determines the number to be redundant, excessive or not in keeping with the federal policies relating to radiation exposure. DentaQuest utilizes the guidelines published by the Department of Health and Human Services, Center for Devices and Radiological Health. These guidelines were developed in conjunction with the Food and Drug Administration and are described in Attachment J of this manual.

An initial examination is typically used when evaluating a patient comprehensively. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. It may require interpretation of information acquired through additional diagnostic procedures. Additional diagnostic procedures should be reported separately.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0120	periodic oral evaluation - established patient	21 and older		No	One of (D0120, D0150) per 6 Month(s) Per patient. Either D0120 or D0150 per 6 months per patient	
D0140	limited oral evaluation-problem focused	21 and older		No	Two of (D0140) per 1 Year(s) Per Provider OR Location.	
D0150	comprehensive oral evaluation - new or established patient	21 and older		No	One of (D0150) per 1 Lifetime Per Provider OR Location. One of (D0120, D0150) per 6 Month(s) Per patient.	
D0180	comprehensive periodontal evaluation - new or established patient	21 and older		No	One of (D0180) per 12 Month(s) Per patient.	
D0220	intraoral - periapical first radiographic image	21 and older		No	One of (D0220) per 1 Day(s) Per Provider OR Location.	
D0230	intraoral - periapical each additional radiographic image	21 and older		No		
D0270	bitewing - single radiographic image	21 and older		No	One of (D0270) per 6 Month(s) Per patient. One of (D0270, D0272, D0274) per 6 Month(s) Per patient.	
D0272	bitewings - two radiographic images	21 and older		No	One of (D0272) per 6 Month(s) Per patient. One of (D0270, D0272, D0274) per 6 Month(s) Per patient.	
D0274	bitewings - four radiographic images	21 and older		No	One of (D0274) per 6 Month(s) Per patient. One of (D0270, D0272, D0274) per 6 Month(s) Per patient.	

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Exhibit D Benefits Covered for
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Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0330	panoramic radiographic image	21 and older		No	One of (D0330) per 36 Month(s) Per patient. One of (D0210, D0330) per 36 Month(s) Per patient.	

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Exhibit D Benefits Covered for
Amerigroup Medicaid Pregnant Women

Diagnostic services include the oral examinations and selected radiographs needed to assess the oral health, diagnose oral pathology and develop an adequate treatment plan for the Participant's oral health.

Reimbursement for radiographs includes exposure of the radiograph, developing, mounting and radiographic interpretation. Reimbursement for multiple radiographs of the same tooth or area may be denied if DentaQuest determines the number to be redundant, excessive or not in keeping with the federal policies relating to radiation exposure. DentaQuest utilizes the guidelines published by the Department of Health and Human Services, Center for Devices and Radiological Health. These guidelines were developed in conjunction with the Food and Drug Administration and are described in Attachment J of this manual.

An initial examination is typically used when evaluating a patient comprehensively. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. It may require interpretation of information acquired through additional diagnostic procedures. Additional diagnostic procedures should be reported separately.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Preventative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1110	prophylaxis - adult	21 and older		No	One of (D1110) per 6 Month(s) Per patient. Includes scaling and polishing procedures to remove coronal plaque, calculus and stains	
D1208	topical application of fluoride - excluding varnish	21 and older		No	One of (D1204, D1206, D1208) per 6 Month(s) Per patient.	

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Restorative services (amalgams and composites) are provided to remove decay and restore dental structures (teeth) to a reasonable condition. Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day.

When restorations involving multiple surfaces are requested or performed, that are outside the usual anatomical expectation, the allowance is limited to that of a one-surface restoration. Any fee charged in excess of the allowance for the one-surface restoration is DISALLOWED.

Bases, cements, liners, pulp caps, bonding agents and local anesthetic are included in the restorative service fees and are not reimbursed separately.

Restorations are expected to last a reasonable amount of time. Repeated unexplained failures will result in review by Peer Review and may necessitate removal of the dentist from the panel.

The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent teeth.

BILLING AND REIMBURSEMENT FOR CAST CROWNS, CAST POST & CORES AND LAMINATE VENEERS OR ANY OTHER FIXED PROSTHETICS SHALL BE BASED ON THE CEMENTATION DATE.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2140	Amalgam - one surface, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2150	Amalgam - two surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2160	amalgam - three surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2161	amalgam - four or more surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2330	resin-based composite - one surface, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	

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Exhibit D Benefits Covered for
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Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2331	resin-based composite - two surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2332	resin-based composite - three surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2391	resin-based composite - one surface, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2392	resin-based composite - two surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2393	resin-based composite - three surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2394	resin-based composite - four or more surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	

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Endodontic services are provided to retain teeth through root canal therapy made necessary due to trauma or carious exposure.

The following guidelines must be followed when providing endodontic services:

Pulpotomies will only be covered on primary teeth with no evidence of internal resorption, furcation or periapical pathologic involvement.

The standard of acceptability employed for endodontic procedures requires that the canal(s) be completely filled apically and laterally. In cases where the root canal filling does not meet DentaQuest's treatment standards, DentaQuest can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Root canal therapy for permanent teeth includes diagnosis, extirpation of the pulp, shaping and enlarging the canals, temporary fillings, filling and obliteration of root canal(s), and progress radiographs. The fee does not include the final restoration. Root canals and pulpotomies may not be covered in the following situations:

* Root resorption has started and exfoliation is imminent
* Gross periapical or periodontal pathosis is demonstrated radiographically (caries to the furcation, or subcrestal deeming the tooth non-restorable)
* The general oral condition does not justify root canal therapy due to the loss of arch integrity
* Tooth does not demonstrate 50% bone support
* Tooth demonstrates active untreated periodontal disease

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Endodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3354	Pulpal regeneration includes completed regenerative trt of an immature perm tooth with a necrotic pulp. Includes removal of intracanal medication and procs necessary to regenerate cont'd root development and neccessary xrays.	21 and older	Teeth 1 - 32	No		

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Exhibit D Benefits Covered for
Amerigroup Medicaid Pregnant Women

Periodontal scaling and root planing, gingivectomy, and certain other procedures as required can be considered for coverage. The initial stages of therapy should include Oral Hygiene Instructions and treatment to remove deposits. Surgical intervention will not be considered until there is a sufficient amount of time for healing and re-evaluation.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Periodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D4240	gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes		
D4241	gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes		
D4341	periodontal scaling and root planing - four or more teeth per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	4 quadrants per 12 months either D4341 or D4342	
D4342	periodontal scaling and root planing - one to three teeth per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	4 quadrants per 12 months either D4341 or D4342	
D4910	periodontal maintenance procedures	21 and older		No	One of (D4910) per 6 Month(s) Per patient.	

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Provisions for removable prosthesis included initial placement when masticatory function is impaired or when existing prosthesis is at least five years old and unserviceable.

All necessary restorative work must be completed before fabrication of a partial denture. Abutments for partial dentures must be free of active periodontal disease, and have at least 50% bone support.

Payment for dentures includes any necessary adjustments, repairs or relines necessary during the six - (6) month period following delivery of a new prosthesis. Relines are covered once every 24 months. The reimbursement for an incomplete denture service (non-delivery) will be limited to the out-of-pocket costs as documented by a copy of the lab bill. THE DATE OF PLACEMENT MUST BE USED AS THE DATE OF SERVICE WHEN SUBMITTING FOR PAYMENT OF DENTURES. Extractions and other procedures necessary prior to denture placement must be rendered and paid before dentures will be reimbursed. If immediate dentures, extractions must be rendered and billed with the same date of service as placement of the immediate dentures.

In situations where it is impractical to obtain pre-operative radiographs on a patient in a nursing home or long term care facility, a written narrative by the dentist stating that the patient is in a physical and mental state sufficient to function with full dentures is required for authorization.

Denture benefits for patients with the following medical conditions will not be considered for coverage:

* Patients on feeding tubes
* Post CVA patients with decreased facial muscle tone
* Patients in a coma
* Patients with diminished mental capacities that could not function with dentures
* Patients who do not desire dentures
* Advanced terminal patients

BILLING AND REIMBURSEMENT FOR CAST CROWNS, CAST POST & CORES AND LAMINATE VENEERS OR ANY OTHER FIXED PROSTHETICS SHALL BE BASED ON THE CEMENTATION DATE.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Maxillofacial Prosthetics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5992	Adjust maxillofacial prosthetic appliance, by report	21 and older	Per Arch (01, 02, LA, UA)	No		
D5993	Maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral) other than required adjustments.	21 and older	Per Arch (01, 02, LA, UA)	No		

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The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent teeth.

BILLING AND REIMBURSEMENT FOR CAST CROWNS, CAST POST & CORES AND LAMINATE VENEERS OR ANY OTHER FIXED PROSTHETICS SHALL BE BASED ON THE CEMENTATION DATE.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Prosthodontics, fixed						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6254	Interim pontic-pontic used as an interim restoration for a duration of less than six months to allow adequate time for healing. This is not a temporaty pontic for routine prosthetic fixed partial denture restoration.	21 and older	Teeth 1 - 32	No		

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Prophylactic removal of multiple asymptomatic teeth, or teeth free from pathology is not a covered benefit.

Extraction of deciduous teeth that radiographically appear to be near imminent exfoliation is not a covered benefit.

Reimbursement includes local anesthesia and post-operative care.

Claims for all oral surgical procedures except simple non surgical extractions must include a pre-operative radiograph to be considered for reimbursement. General Dentists are required to submit authorizations and pre-operative radiographs for CDT code D7210 and higher.

Simple and surgical extractions are covered. Local anesthesia and routine post-operative care are included in the fees and will not be reimbursed separately.

“Erupted surgical extractions” are defined as extractions requiring elevation of a mucoperiosteal flap and removal of bone, and/or section of the tooth and closure.

Tuberosity reductions are not payable in conjunction with extractions or alveolectomy in the same quadrant.

For oral surgery performed as part of emergency care, the requirement for prior authorization is waived. Service will still be subject to retrospective review. Emergency care is defined as treatment of pain, infection, swelling, uncontrolled bleeding, or traumatic injury.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7111	extraction, coronal remnants - primary tooth	21 and older	Teeth A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	21 and older	Teeth 1 - 3, 14 - 19, 30 - 32, 51 - 53, 64 - 69, 80 - 82	Yes	Prophylatic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit	
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	21 and older	Teeth 4 - 13, 20 - 29, 54 - 63, 70 - 79, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Prophylatic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit	

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Exhibit D Benefits Covered for Amerigroup Medicaid Pregnant Women

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7220	removal of impacted tooth-soft tissue	21 and older	Teeth 1 - 32, 51 - 82	Yes	Prophylatic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit	
D7230	removal of impacted tooth-partially bony	21 and older	Teeth 1 - 32, 51 - 82	Yes	Prophylatic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit	
D7240	removal of impacted tooth-completely bony	21 and older	Teeth 1 - 32, 51 - 82	Yes	Prophylatic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit	
D7250	surgical removal of residual tooth roots (cutting procedure)	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Not reimbursable to the provider performing the extraction	
D7251	Coronectomy-intentional partial tooth removal is performed when a neurovascular complication is likely if the entire impacted tooth is removed.	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	21 and older	Teeth 1 - 32	Yes	Limited to one per accident regardless of the number of teeth involved and covers all needed services (i.e. splints, suturing, follow-up care)	
D7286	incisional biopsy of oral tissue-soft	21 and older		Yes	For removal of architecturary intact specimen only. Not to be used with apicoectomy or periradicular curittage	
D7295	Harvest of bone for use in autogenous grafting procedure	21 and older		No		
D7510	incision and drainage of abscess - intraoral soft tissue	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Either D7510 or D7511 on date of service	
D7520	incision and drainage of abscess - extraoral soft tissue	21 and older		Yes	Either D7510 or D7511 on date of service	
D7540	removal of reaction-producing foreign bodies, musculoskeletal system	21 and older		Yes		

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Exhibit D Benefits Covered for
Amerigroup Medicaid Pregnant Women

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7610	maxilla - open reduction	21 and older		Yes	Fractures must be billed to include acrylic splints, any necessary wiring, office and post-op visits, radiographs, and suturing	
D7620	maxilla - closed reduction	21 and older		Yes	Fractures must be billed to inlcude acrylic splints, any necessary wiring, office and post-op visits, radiographs, and suturing	
D7630	mandible-open reduction	21 and older		Yes	Fractures must be billed to include acrylic splints, any necessary wiring, office and post-op visits, radiographs, and suturing	
D7640	mandible - closed reduction	21 and older		Yes	Fractures must be billed to include acrylic splints any necessary wiring, office and post-op visits, radiographs, and suturing	
D7820	closed reduction dislocation	21 and older		Yes	Must be billed to include office and post-op visits, radiographs, and suturing	
D7910	suture small wounds up to 5 cm	21 and older		Yes	Excludes closure of surgical incisions. Not to be used in conjunction with extractions	
D7912	complex suture - greater than 5cm	21 and older		Yes	Excludes closure of surgical incisions. Not to be used in conjunction with extractions	

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Exhibit D Benefits Covered for
Amerigroup Medicaid Pregnant Women

Adjunctive general services include general anesthesia, intravenous sedation, nitrous oxide analgesia, consultations and various drugs and medicaments, and emergency services provided for relief of dental pain.

Intravenous sedation and general anesthesia will only be a covered service for participating dentists that hold current certification and licensure per state and federal guidelines.

Requests for intravenous sedation and general anesthesia will be reviewed on a case by case basis. A case will be covered for Participants with physical or mental health problems of such severity that treatment can not be reasonably attempted without the use of intravenous sedation or general anesthesia. Intravenous sedation or general anesthesia may be allowed when a surgical procedure is being rendered. Claims for intravenous sedation and general anesthesia must include a narrative of medical necessity. Acceptable conditions include:

* Toxicity to local anesthesia supported by documentation;
* Severe mental retardation;
* Severe physical disability;
* Uncontrolled management problem;
* Extensive or complicated surgical procedures;
* Failure of local anesthesia;
* Documented medical complications; and
* Acute infection that would preclude the efficacy of local anesthesia.

For cases requiring intravenous sedation or general anesthesia, Providers must document the following in the Participant's chart for appropriate psychosomatic disorders: diagnosis, description of past evidence of situational anxiety or uncontrolledbehaviors, and in the case of referral due to uncontrolled behavior, the name of the referring dentist or provider group. Apprehension alone is not typically considered medically necessary. DentaQuest may elect to perform chart audits on these services. Services not documented as required may be denied for payment. The procedures will only be reimbursed for once per day regardless of the length of time it takes to complete the procedure.

General anesthesia, intravenous sedation, and nitrous oxide are only covered in conjunction with a covered dental procedure. Payment for any one of these services precludes payment for the remaining procedure codes. Payment for general anesthesia or intravenous sedation includes any other drugs administered on the same day.

Reimbursement for local anesthesia is included in the fee for the procedures.

Procedure code D9230 – nitrous oxide, is a covered service for Participants who are mentally or physically challenged, or otherwise present with special management needs.

Only claims for nitrous oxide with documented medical necessity will be considered for payment. Medical necessity for the use of nitrous oxide would be broadly defined as some condition specific to the particular treatment situation that would preclude the performance of necessary dental treatment, with the use of a local anesthetic alone. Situations for nitrous oxide will be reviewed for coverage on a case by case basis.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

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Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9110	palliative (emergency) treatment of dental pain - minor procedure	21 and older		No		
D9215	local anesthesia in conjunction with operative or surgical procedures	21 and older		No	Not to be used in conjunction with treatment	
D9222	deep sedation/general anesthesia – first 15 minutes	21 and older		Yes	One of (D9222) per 1 Day(s) Per patient. Not allowed in conjunction with D9230, D9239, D9243, D9248 or D9920.	narrative of medical necessity
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment	21 and older		Yes	Eight of (D9223) per 1 Day(s) Per patient.	
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	21 and older		No		
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	21 and older		Yes	One of (D9239) per 1 Day(s) Per patient.	narrative of medical necessity
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	21 and older		Yes	Eight of (D9243) per 1 Day(s) Per patient.	
D9248	non-intravenous moderate (conscious) sedation	21 and older		Yes		
D9440	office visit - after regularly scheduled hours	21 and older		No	Two of (D9440) per 1 Year(s) Per Provider AND Location.	

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Exhibit E Benefits Covered for Amerigroup Interpregnancy CARE

Diagnostic services include the oral examinations and selected radiographs needed to assess the oral health, diagnose oral pathology and develop an adequate treatment plan for the Participant's oral health.

Reimbursement for radiographs includes exposure of the radiograph, developing, mounting and radiographic interpretation. Reimbursement for multiple radiographs of the same tooth or area may be denied if DentaQuest determines the number to be redundant, excessive or not in keeping with the federal policies relating to radiation exposure. DentaQuest utilizes the guidelines published by the Department of Health and Human Services, Center for Devices and Radiological Health. These guidelines were developed in conjunction with the Food and Drug Administration and are described in Attachment J of this manual.

An initial examination is typically used when evaluating a patient comprehensively. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. It may require interpretation of information acquired through additional diagnostic procedures. Additional diagnostic procedures should be reported separately.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0120	periodic oral evaluation - established patient	21 and older		No	One of (D0120) per 6 Month(s) Per patient.	
D0220	intraoral - periapical first radiographic image	21 and older		No		
D0230	intraoral - periapical each additional radiographic image	21 and older		No		
D0270	bitewing - single radiographic image	21 and older		No	One of (D0270) per 6 Month(s) Per patient. One of (D0270, D0272, D0274) per 6 Month(s) Per patient.	
D0272	bitewings - two radiographic images	21 and older		No	One of (D0272) per 6 Month(s) Per patient. One of (D0270, D0272, D0274) per 6 Month(s) Per patient.	
D0274	bitewings - four radiographic images	21 and older		No	One of (D0274) per 6 Month(s) Per patient. One of (D0270, D0272, D0274) per 6 Month(s) Per patient.	
D0330	panoramic radiographic image	21 and older		No	One of (D0330) per 36 Month(s) Per patient.	

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Exhibit E Benefits Covered for
Amerigroup Interpregnancy CARE

Preventive services include routine prophylaxis (including scaling and polishing) for Participants over age 21. The goal of providing routine and periodic preventive dental services is to maintain oral health and prevent more extensive dental procedures.

Routine prophylaxis is covered for Participants over age 21, once every 6 months. Prophylaxis includes necessary scaling and polishing.

A lower lingual holding arch placed when there is not premature loss of a primary molar is considered a transitional orthodontic appliance and not a covered benefit.

PLACE OF SERVICE (field #38 on 2002, 2004 ADA claim form) MUST BE INDICATED ON ALL CLAIMS.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Preventative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1110	prophylaxis - adult	21 and older		No	One of (D1110) per 6 Month(s) Per patient.	

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Exhibit E Benefits Covered for
Amerigroup Interpregnancy CARE

Prophylactic removal of multiple asymptomatic teeth, or teeth free from pathology is not a covered benefit.

Extraction of deciduous teeth that radiographically appear to be near imminent exfoliation is not a covered benefit.

Reimbursement includes local anesthesia and post-operative care.

Claims for all oral surgical procedures except simple non surgical extractions must include a pre-operative radiograph to be considered for reimbursement. General Dentists are required to submit authorizations and pre-operative radiographs for CDT code D7210 and higher.

Simple and surgical extractions are covered. Local anesthesia and routine post-operative care are included in the fees and will not be reimbursed separately.

“Erupted surgical extractions” are defined as extractions requiring elevation of a mucoperiosteal flap and removal of bone, and/or section of the tooth and closure.

Tuberosity reductions are not payable in conjunction with extractions or alveolectomy in the same quadrant.

For oral surgery performed as part of emergency care, the requirement for prior authorization is waived. Service will still be subject to retrospective review. Emergency care is defined as treatment of pain, infection, swelling, uncontrolled bleeding, or traumatic injury.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		

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Adjunctive general services include general anesthesia, intravenous sedation, nitrous oxide analgesia, consultations and various drugs and medicaments, and emergency services provided for relief of dental pain.

Intravenous sedation and general anesthesia will only be a covered service for participating dentists that hold current certification and licensure per state and federal guidelines.

Requests for intravenous sedation and general anesthesia will be reviewed on a case by case basis. A case will be covered for Participants with physical or mental health problems of such severity that treatment can not be reasonably attempted without the use of intravenous sedation or general anesthesia. Intravenous sedation or general anesthesia may be allowed when a surgical procedure is being rendered. Claims for intravenous sedation and general anesthesia must include a narrative of medical necessity. Acceptable conditions include:

* Toxicity to local anesthesia supported by documentation;
* Severe mental retardation;
* Severe physical disability;
* Uncontrolled management problem;
* Extensive or complicated surgical procedures;
* Failure of local anesthesia;
* Documented medical complications; and
* Acute infection that would preclude the efficacy of local anesthesia.

For cases requiring intravenous sedation or general anesthesia, Providers must document the following in the Participant's chart for appropriate psychosomatic disorders: diagnosis, description of past evidence of situational anxiety or uncontrolledbehaviors, and in the case of referral due to uncontrolled behavior, the name of the referring dentist or provider group. Apprehension alone is not typically considered medically necessary. DentaQuest may elect to perform chart audits on these services. Services not documented as required may be denied for payment. The procedures will only be reimbursed for once per day regardless of the length of time it takes to complete the procedure.

General anesthesia, intravenous sedation, and nitrous oxide are only covered in conjunction with a covered dental procedure. Payment for any one of these services precludes payment for the remaining procedure codes. Payment for general anesthesia or intravenous sedation includes any other drugs administered on the same day.

Reimbursement for local anesthesia is included in the fee for the procedures.

Procedure code D9230 – nitrous oxide, is a covered service for Participants who are mentally or physically challenged, or otherwise present with special management needs.

Only claims for nitrous oxide with documented medical necessity will be considered for payment. Medical necessity for the use of nitrous oxide would be broadly defined as some condition specific to the particular treatment situation that would preclude the performance of necessary dental treatment, with the use of a local anesthetic alone. Situations for nitrous oxide will be reviewed for coverage on a case by case basis.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

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Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	21 and older		No	Not allowed with D9248.	
D9248	non-intravenous moderate (conscious) sedation	21 and older		Yes	Not allowed wtih D9230.	

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Exhibit F Benefits Covered for
Amerigroup Georgia Families 360° Medicaid

Diagnostic services include the oral examinations, school based examinations and selected radiographs needed to assess the oral health, diagnose oral pathology and develop an adequate treatment plan for the Participant's oral health.

Reimbursement for radiographs includes exposure of the radiograph, developing, mounting and radiographic interpretation. Reimbursement for multiple radiographs of the same tooth or area may be denied if DentaQuest determines the number to be redundant, excessive or not in keeping with the federal policies relating to radiation exposure. DentaQuest utilizes the guidelines published by the Department of Health and uman Services, Center for Devices and Radiological Health. These guidelines were developed in conjunction with the Food and Drug Administration and are described in Attachment J of this manual.

If the total allowed amount for radiographs performed on a participant exceeds the allowed amount for procedure code D0210 (Complete Series), the submitted radiograph codes will be consolidated and paid as a Complete Series (D0210). The maximum reimbursement for a single date of service for radiographs shall be limited to the fee for a complete series.

A comprehensive oral evaluation (D0150) is typically used when evaluating a patient comprehensively. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. It may require interpretation of information acquired through additional diagnostic procedures. Additional diagnostic procedures should be reported separately.

This would include the evaluation and recording of the patient's dental and medical history and a general health assessment. It may typically include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, oral cancer screening, etc.

A periodic oral evaluation (D0120) is performed on a patient of record to determine any changes in the patient's dental and medical health status since a previous comprehensive or periodic evaluation. This may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately.

A complete Early Periodic Screening, Diagnosis and Treatment (EPSDT) school based examination is used when evaluating a patient comprehensively. It is a thorough evaluation and a recording of the extraoral and intraoral hard and soft tissues. This would include the evaluation and recording of the patient's dental and medical history and a general health assessment. It may typically include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, oral cancer screening, etc. if medically necessary to render D0150, D0210, D0272, D0274, D0330, or D1203 outside of established age parameters. Coverage Exception Request Form may be submitted prospectively for consideration (see Appendix- A 13)

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0120	periodic oral evaluation - established patient	0-20		No	One of (D0120, D0150) per 6 Month(s) Per patient. Either D0120 or D0150.	
D0140	limited oral evaluation-problem focused	0-20		No	Two of (D0140) per 1 Year(s) Per patient.	

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Exhibit F Benefits Covered for
Amerigroup Georgia Families 360° Medicaid

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0150	comprehensive oral evaluation - new or established patient	0-20		No	One of (D0150) per 1 Lifetime Per Provider OR Location. One of (D0120, D0150) per 6 Month(s) Per patient.	
D0210	intraoral - complete series of radiographic images	6 - 20		No	One of (D0210) per 36 Month(s) Per patient. One of (D0210, D0330) per 36 Month(s) Per patient.	
D0220	intraoral - periapical first radiographic image	0-20		No		
D0230	intraoral - periapical each additional radiographic image	0-20		No		
D0240	intraoral - occlusal radiographic image	0-20		No		
D0270	bitewing - single radiographic image	0-20		No	One of (D0270, D0272, D0274) per 6 Month(s) Per patient.	
D0272	bitewings - two radiographic images	2 - 20		No	One of (D0270, D0272, D0274) per 6 Month(s) Per patient.	
D0274	bitewings - four radiographic images	10 - 20		No	One of (D0270, D0272, D0274) per 6 Month(s) Per patient.	
D0330	panoramic radiographic image	6 - 20		No	One of (D0330) per 36 Month(s) Per patient. One of (D0210, D0330) per 36 Month(s) Per patient.	

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Exhibit F Benefits Covered for
Amerigroup Georgia Families 360° Medicaid

Preventive services include routine and EPSDT prophylaxis (including scaling and polishing), topical fluoride treatments, dental sealants, and space maintenance therapy. The goal of providing routine and periodic preventive dental services is to maintain oral health and prevent more extensive dental procedures.

Routine prophylaxis is covered for Participants age 0 through 20, once per 6 months. Prophylaxis includes necessary scaling and polishing.

The topical application of fluoride treatment is allowed once per 6 months for Participants age 2 through 13.

Sealants are covered for Participants age 5 through 17. Sealants should be applied to the occlusal surfaces of all erupted and appropriate first and second permanent molars. Priority should be given to applying sealants for all 7 and 12 year olds. Sealants will not be covered when they are placed over restorations.

A lower lingual holding arch placed when there is not premature loss of a primary molar is considered a transitional orthodontic appliance and not a covered benefit.

PLACE OF SERVICE (field #38 on 2002, 2004 ADA claim form) MUST BE INDICATED ON ALL CLAIMS.

THE DATE OF PLACEMENT MUST BE USED AS THE DATE OF SERVICE WHEN SUBMITTING FOR PAYMENT OF SPACE MAINTAINERS.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Preventative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1110	prophylaxis - adult	14 - 20		No	One of (D1110) per 6 Month(s) Per patient.	
D1120	prophylaxis - child	0-13		No	One of (D1120) per 6 Month(s) Per patient. Removal of plaque, calculus and stains from the tooth surfaces. Intended to control local irrational factors.	
D1206	topical application of fluoride varnish	0-13		No	One of (D1203, D1206, D1208) per 6 Month(s) Per patient.	
D1208	topical application of fluoride - excluding varnish	2-13		No	One of (D1203, D1206, D1208) per 6 Month(s) Per patient. Prescription strength fluoride designed soley for use in the dental office, delivered to the dentition under the direct supervision of a dental professional.	
D1351	sealant - per tooth	5-17	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	One of (D1351) per 4 Year(s) Per patient per tooth. Occlusal surfaces only. Teeth must be caries free. Sealant will not be covered when placed over restorations.	

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Exhibit F Benefits Covered for
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Preventative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1510	space maintainer-fixed-unilateral	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	Covered when indicated due to premature loss of posterior primary teeth.	
D1515	space maintainer - fixed - bilateral	0-20	Per Arch (01, 02, LA, UA)	No	Covered when indicated due to premature loss of posterior primary teeth.	
D1525	space maintainer-removable-bilateral	0-20	Per Arch (01, 02, LA, UA)	No	Covered when indicated due to premature loss of posterior primary teeth.	
D1550	re-cement or re-bond space maintainer	0-20		No	Covered when indicated due to premature loss of posterior primary teeth.	

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Exhibit F Benefits Covered for
Amerigroup Georgia Families 360° Medicaid

Restorative services (amalgams and composites) are provided to remove decay and restore dental structures (teeth) to a reasonable condition. Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day.

When restorations involving multiple surfaces are requested or performed, that are outside the usual anatomical expectation, the allowance is limited to that of a one-surface restoration. Any fee charged in excess of the allowance for the one-surface restoration is DISALLOWED.

Bases, cements, liners, pulp caps, bonding agents and local anesthetic are included in the restorative service fees and are not reimbursed separately.

Generally, once a particular restoration is placed in a tooth, a similar restoration will not be covered for at least 12 months. Restorations are expected to last a reasonable amount of time. Repeated unexplained failures will result in review by Peer Review and may necessitate removal of the dentist from the panel.

The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent teeth.

BILLING AND REIMBURSEMENT FOR CAST CROWNS, CAST POST & CORES AND LAMINATE VENEERS OR ANY OTHER FIXED PROSTHETICS SHALL BE BASED ON THE CEMENTATION DATE.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2140	Amalgam - one surface, primary or permanent	0-20	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. One restorative filling per tooth per restoration. Max number of surfaces to be reimbursed is 4.	
D2150	Amalgam - two surfaces, primary or permanent	0-20	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. One restorative filling per tooth per restoration. Max number of surfaces to be reimbursed is 4.	
D2160	amalgam - three surfaces, primary or permanent	0-20	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. One restorative filling per tooth per restoration. Max number of surfaces to be reimbursed is 4.	

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Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2161	amalgam - four or more surfaces, primary or permanent	0-20	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. One restorative filling per tooth per restoration. Max number of surfaces to be riembursed is 4.	
D2330	resin-based composite - one surface, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. One restorative filling per tooth per restoration. Max number of surfaces to be reimbursed is 4.	
D2331	resin-based composite - two surfaces, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. One restorative filling per tooth per restoration. Max number of surfaces to be reimbursed is 4.	
D2332	resin-based composite - three surfaces, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. One restorative filling per tooth per restoration. Max number of surfaces to be reimbursed is 4.	
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2391	resin-based composite - one surface, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. One restorative filling per tooth per restoration. Max number of surfaces to be reimbursed is 4.	

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Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2392	resin-based composite - two surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. One restorative filling per tooth per restoration. Max number of surfaces to be reimbursed is 4.	
D2393	resin-based composite - three surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2394	resin-based composite - four or more surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. One restorative filling per tooth per restoration. Max number of surfaces to be reimbursed is 4.	
D2920	re-cement or re-bond crown	0-20	Teeth 1 - 32, A - T	No	One restorative filling per tooth per restoration. Max number of surfaces to be reimbursed is 4.	
D2930	prefabricated stainless steel crown - primary tooth	0-20	Teeth A - T	No	One of (D2930, D2934) per 1 Lifetime Per Provider OR Location per tooth.	
D2931	prefabricated stainless steel crown-permanent tooth	2 - 20	Teeth 1 - 32	No	One of (D2931) per 60 Month(s) Per Provider OR Location per tooth. One restorative filling per tooth per restoration. Max number of surfaces to be reimbursed is 4.	
D2932	prefabricated resin crown	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2932) per 60 Month(s) Per Provider OR Location per tooth.	
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	0-20	Teeth A - T	No	One of (D2930, D2934) per 1 Lifetime Per Provider OR Location per tooth. One restorative filling per tooth per restoration. Max number of surfaces to be reimbursed is 4	
D2940	protective restoration	0-20	Teeth 1 - 32, A - T	No	One restorative filling per tooth per restoration. Max number of surfaces to be reimbursed is 4.	
D2951	pin retention - per tooth, in addition to restoration	0-20	Teeth 1 - 32	No	One restorative filling per tooth per restoration. Max number of surfaces to be reimbursed is 4.	

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Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2954	prefabricated post and core in addition to crown	0-20	Teeth 1 - 32	No	One restorative filling per tooth per restoration. Max number of surfaces to be reimbursed is 4.	

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Endodontic services are provided to retain teeth through root canal therapy made necessary due to trauma or carious exposure.

The following guidelines must be followed when providing endodontic services:

Pulpotomies will only be covered on primary teeth with no evidence of internal resorption, furcation or periapical pathologic involvement.

The standard of acceptability employed for endodontic procedures requires that the canal(s) be completely filled apically and laterally. In cases where the root canal filling does not meet DentaQuest's treatment standards, DentaQuest can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Root canal therapy for permanent teeth includes diagnosis, extirpation of the pulp, shaping and enlarging the canals, temporary fillings, filling and obliteration of root canal(s), and progress radiographs. The fee does not include the final restoration.

Root canals and pulpotomies may not be covered in the following situations:

* Root resorption has started and exfoliation is imminent
* Gross periapical or periodontal pathosis is demonstrated radiographically (caries to the furcation, or subcrestal deeming the tooth non-restorable)
* The general oral condition does not justify root canal therapy due to the loss of arch integrity
* Tooth does not demonstrate 50% bone support
* Tooth demonstrates active untreated periodontal disease

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Endodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	0-20	Teeth 1 - 32, A - T	No	Not reimbursable when performed in conjunction with root canal therapy.	
D3221	pulpal debridement, primary and permanent teeth	0-20	Teeth 1 - 32, A - T	No		
D3310	endodontic therapy, anterior tooth (excluding final restoration)	2 - 20	Teeth 6 - 11, 22 - 27	No	One per Lifetime Per Tooth.	
D3320	endodontic therapy, premolar tooth (excluding final restoration)	2 - 20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	One per Lifetime Per Tooth.	

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Endodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3354	Pulpal regeneration includes completed regenerative trt of an immature perm tooth with a necrotic pulp. Includes removal of intracanal medication and procs necessary to regenerate cont'd root development and neccessary xrays.	0-20	Teeth 1 - 32	No		
D3410	apicoectomy - anterior	2 - 20	Teeth 6 - 11, 22 - 27	Yes	Not payable concurrently with root canal treatment of tooth.	
D3426	apicoectomy (each additional root)	0-20	Teeth 1 - 5, 12 - 21, 28 - 32	No		

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Periodontal scaling and root planing, gingivectomy, and certain other procedures as required can be considered for coverage. The initial stages of therapy should include Oral Hygiene Instructions and treatment to remove deposits. Surgical intervention will not be considered until there is a sufficient amount of time for healing and re-evaluation.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Periodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210) per 12 Month(s) Per patient per quadrant.	
D4240	gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4240) per 12 Month(s) Per patient per quadrant.	
D4260	osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4260) per 12 Month(s) Per patient per quadrant.	
D4270	pedicle soft tissue graft procedure	0-20	Teeth 1 - 32	Yes		
D4271	free soft tissue graft procedure	0-20	Teeth 1 - 32	Yes		
D4341	periodontal scaling and root planing - four or more teeth per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4341) per 1 Calendar year(s) Per patient per quadrant. One full mouth per patient per calendar year.	

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Provisions for removable prosthesis included initial placement when masticatory function is impaired or when existing prosthesis is at least five years old and unserviceable. All necessary restorative work must be completed before fabrication of a partial denture. Abutments for partial dentures must be free of active periodontal disease, and have at least 50% bone support.

Payment for dentures includes any necessary adjustments, repairs or relines necessary during the six - (6) month period following delivery of a new prosthesis. Relines are covered once every 24 months. The reimbursement for an incomplete denture service (non-delivery) will be limited to the out-of-pocket costs as documented by a copy of the lab bill. THE DATE OF PLACEMENT MUST BE USED AS THE DATE OF SERVICE WHEN SUBMITTING FOR PAYMENT OF DENTURES. Extractions and other procedures necessary prior to denture placement must be rendered and paid before dentures will be reimbursed. If immediate dentures, extractions must be rendered and billed with the same date of service as placement of the immediate dentures.

In situations where it is impractical to obtain pre-operative radiographs on a patient in a nursing home or long term care facility, a written narrative by the dentist stating that the patient is in a physical and mental state sufficient to function with full dentures is required for authorization.

Denture benefits for patients with the following medical conditions will not be considered for coverage:

* Patients on feeding tubes
* Post CVA patients with decreased facial muscle tone
* Patients in a coma
* Patients with diminished mental capacities that could not function with dentures
* Patients who do not desire dentures
* Advanced terminal patients

A partial denture that replaces only posterior permanent teeth must include three or more teeth on the dentures that are anatomically correct (natural size, shape, and color) to be compensable (excluding third molars). Partial dentures must include one anterior tooth and/or 3 posterior teeth (excluding third molars).

Fabrication of a removable prosthetic includes multiple steps(appointments) these multiple steps (impressions, try-in appointments, delivery etc.) are inclusive in the fee for the removable prosthetic and as such not eligible for additional compensation.

BILLING AND REIMBURSEMENT FOR CAST CROWNS, CAST POST & CORES AND LAMINATE VENEERS OR ANY OTHER FIXED PROSTHETICS SHALL BE BASED ON THE CEMENTATION DATE.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5110	complete denture - maxillary	0-20	Per Arch (01, UA)	Yes	One of (D5110) per 36 Month(s) Per patient.	
D5120	complete denture - mandibular	0-20	Per Arch (02, LA)	Yes	One of (D5120) per 36 Month(s) Per patient.	

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Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5130	immediate denture - maxillary	0-20	Per Arch (01, UA)	Yes	One of (D5130) per 1 Lifetime Per patient.	
D5140	immediate denture - mandibular	0-20	Per Arch (02, LA)	Yes	One of (D5140) per 1 Lifetime Per patient.	
D5211	maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	2 - 20		Yes	One of (D5211) per 36 Month(s) Per patient.	
D5212	mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	2 - 20		Yes	One of (D5212) per 36 Month(s) Per patient.	
D5410	adjust complete denture - maxillary	0-20		No	Two of (D5410) per 1 Year(s) Per patient.	
D5411	adjust complete denture - mandibular	0-20		No	Two of (D5411) per 1 Year(s) Per patient.	
D5421	adjust partial denture-maxillary	0-20		No	Two of (D5421) per 1 Year(s) Per patient.	
D5422	adjust partial denture - mandibular	0-20		No	Two of (D5422) per 1 Year(s) Per patient.	
D5511	repair broken complete denture base, mandibular	0-20		No	One of (D5511) per 12 Month(s) Per patient.	
D5512	repair broken complete denture base, maxillary	0-20		No	One of (D5512) per 12 Month(s) Per patient.	
D5640	replace broken teeth-per tooth	0-20	Teeth 1 - 32	No		
D5650	add tooth to existing partial denture	0-20	Teeth 1 - 32	No		
D5660	add clasp to existing partial denture	0-20		No		
D5750	reline complete maxillary denture (laboratory)	0-20		No	Two of (D5750) per 1 Year(s) Per patient.	
D5751	reline complete mandibular denture (laboratory)	0-20		No	Two of (D5751) per 1 Year(s) Per patient.	
D5850	tissue conditioning, maxillary	0-20		No	Two of (D5850) per 1 Year(s) Per patient.	
D5851	tissue conditioning,mandibular	0-20		No	Two of (D5851) per 1 Year(s) Per patient.	

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Provisions for removable prosthesis included initial placement when masticatory function is impaired or when existing prosthesis is at least five years old and unserviceable. All necessary restorative work must be completed before fabrication of a partial denture. Abutments for partial dentures must be free of active periodontal disease, and have at least 50% bone support.

Payment for dentures includes any necessary adjustments, repairs or relines necessary during the six - (6) month period following delivery of a new prosthesis. Relines are covered once every 24 months. The reimbursement for an incomplete denture service (non-delivery) will be limited to the out-of-pocket costs as documented by a copy of the lab bill. THE DATE OF PLACEMENT MUST BE USED AS THE DATE OF SERVICE WHEN SUBMITTING FOR PAYMENT OF DENTURES. Extractions and other procedures necessary prior to denture placement must be rendered and paid before dentures will be reimbursed. If immediate dentures, extractions must be rendered and billed with the same date of service as placement of the immediate dentures.

In situations where it is impractical to obtain pre-operative radiographs on a patient in a nursing home or long term care facility, a written narrative by the dentist stating that the patient is in a physical and mental state sufficient to function with full dentures is required for authorization.
Denture benefits for patients with the following medical conditions will not be considered for coverage:

* Patients on feeding tubes
* Post CVA patients with decreased facial muscle tone
* Patients in a coma
* Patients with diminished mental capacities that could not function with dentures
* Patients who do not desire dentures
* Advanced terminal patients

BILLING AND REIMBURSEMENT FOR CAST CROWNS, CAST POST & CORES AND LAMINATE VENEERS OR ANY OTHER FIXED PROSTHETICS SHALL BE BASED ON THE CEMENTATION DATE.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Maxillofacial Prosthetics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5992	Adjust maxillofacial prosthetic appliance, by report	0-20	Per Arch (01, 02, LA, UA)	No		
D5993	Maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral) other than required adjustments.	0-20	Per Arch (01, 02, LA, UA)	No		

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Fixed bridgework will only be considered for the replacement of the permanent anterior teeth.

Fixed Prosthetic Services are covered for Participants with prior authorization. Services will not be authorized until it is documented that all necessary restorative, endodontic, periodontic and oral surgery has been completed.

Fixed bridgework will not be allowed in conjunction with the placement of a partial denture in the same arch.

Fixed prosthesis will not be covered when they replace a removable appliance that is less than 5 years old.

The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent teeth.

BILLING AND REIMBURSEMENT FOR CAST CROWNS, CAST POST & CORES AND LAMINATE VENEERS OR ANY OTHER FIXED PROSTHETICS SHALL BE BASED ON THE CEMENTATION DATE.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Prosthodontics, fixed						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6254	Interim pontic-pontic used as an interim restoration for a duration of less than six months to allow adequate time for healing. This is not a temporaty pontic for routine prosthetic fixed partial denture restoration.	0-20	Teeth 1 - 32	No		

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Prophylactic removal of multiple asymptomatic teeth, or teeth free from pathology is not a covered benefit.

Extraction of deciduous teeth that radiographically appear to be near imminent exfoliation is not a covered benefit.

Reimbursement includes local anesthesia and post-operative care. Claims for all oral surgical procedures except simple non surgical extractions must include a pre-operative radiograph to be considered for reimbursement. General Dentists are required to submit authorizations and pre-operative radiographs for CDT code D7210 and higher.

Simple and surgical extractions are covered. Local anesthesia and routine post-operative care are included in the fees and will not be reimbursed separately.

"Erupted surgical extractions" are defined as extractions requiring elevation of a mucoperiosteal flap and removal of bone, and/or section of the tooth and closure.

Tuberosity reductions are not payable in conjunction with extractions or alveolectomy in the same quadrant.

For oral surgery performed as part of emergency care, the requirement for prior authorization is waived. Service will still be subject to retrospective review. Emergency care is defined as treatment of pain, infection, swelling, uncontrolled bleeding, or traumatic injury.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7111	extraction, coronal remnants - primary tooth	0-20	Teeth A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No limit. Prophylatic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No limit. Prophylatic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	0-20	Teeth 1 - 3, 14 - 19, 30 - 32, 51 - 53, 64 - 69, 80 - 82	Yes	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	0-20	Teeth 4 - 13, 20 - 29, 54 - 63, 70 - 79, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	
D7220	removal of impacted tooth-soft tissue	0-20	Teeth 1 - 32, 51 - 82	Yes		

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Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7230	removal of impacted tooth-partially bony	0-20	Teeth 1 - 32, 51 - 82	Yes		
D7240	removal of impacted tooth-completely bony	0-20	Teeth 1 - 32, 51 - 82	Yes		
D7250	surgical removal of residual tooth roots (cutting procedure)	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	No limit. Prophylatic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	
D7251	Coronectomy-intentional partial tooth removal is performed when a neurovascular complication is likely if the entire impacted tooth is removed.	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7260	oroantral fistula closure	0-20		Yes		
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	0-20	Teeth 1 - 32	Yes	Limited to one per accident regardless of the number of teeth involved and covers all needed services (i.e. splints, suturing, follow-up care).	
D7280	Surgical access of an unerupted tooth	2 - 20	Teeth 1 - 32	Yes	To expose crown of an impacted tooth not intended to be extracted.	
D7286	incisional biopsy of oral tissue-soft	0-20		Yes	For removal of arch itecturally intact specimen only. Not to be used with apicoectomy or periradicular curittage.	
D7295	Harvest of bone for use in autogenous grafting procedure	0-20		No		
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	2 - 20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One per lifetime per tooth.	
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	2 - 20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One per lifetime per tooth.	
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	2 - 20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One per lifetime per tooth.	

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Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	2 - 20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One per lifetime per tooth.	
D7440	excision of malignant tumor - lesion diameter up to 1.25cm	0-20		Yes		
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	0-20		Yes		
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm	0-20		Yes		
D7460	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm	0-20		Yes		
D7461	removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm	0-20		Yes		
D7471	removal of exostosis - per site	0-20	Per Arch (01, 02, LA, UA)	Yes		
D7510	incision and drainage of abscess - intraoral soft tissue	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes		
D7520	incision and drainage of abscess - extraoral soft tissue	0-20		Yes		
D7540	removal of reaction-producing foreign bodies, musculoskeletal system	0-20		Yes		
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes		
D7610	maxilla - open reduction	0-20		Yes	Fractures must be billed to include acrylic splints, any necessary wiring, office and post op visits, radiographs, and sutures.	
D7620	maxilla - closed reduction	0-20		Yes	Fractures must be billed to include acrylic splints, any necessary wiring, office and post op visits, radiographs, and sutures.	
D7630	mandible-open reduction	0-20		Yes	Fractures must be billed to include acrylic splints, any necessary wiring, office and post op visits, radiographs, and sutures.	

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Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7640	mandible - closed reduction	0-20		Yes	Fractures must be billed to include acrylic splints, any necessary wiring, office and post op visits, radiographs, and sutures.	
D7820	closed reduction dislocation	0-20		Yes	Must be billed to include office and post-op visits, radiographs, and sutures.	
D7910	suture small wounds up to 5 cm	0-20		Yes	Excludes closure of surgical icisions. Not to be used in conjunction with extractions.	
D7912	complex suture - greater than 5cm	0-20		Yes	Excludes closure of surgical icisions. Not to be used in conjunction with extractions.	
D7960	frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another procedure	2 - 20		Yes		
D7970	excision of hyperplastic tissue - per arch	0-20	Per Arch (01, 02, LA, UA)	Yes		
D7971	excision of pericoronal gingiva	0-20	Teeth 1 - 32	Yes		
D7997	appliance removal (not by dentist who placed appliance), includes removal of archbar	0-20		Yes	Not to be billed by dentist who placed appliance.	

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Exhibit F Benefits Covered for
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Participants between the ages of 2 and 20 may qualify for orthodontic care under the program. PARTICIPANTS MUST HAVE A SEVERE, DYSFUNCTIONAL, HANDICAPPING MALOCCLUSION OR OBJECTIVE DOCUMENTATION THAT THE MALOCCLUSION IS AN IMPAIRMENT OF, OR A HAZARD TO THE ABILITY TO EAT, CHEW, SPEAK, OR BREATHE. When it is determined that the case will not qualify for comprehensive orthodontic treatment, the initial examination (consultation) can be billed using procedure code D8999.

Since a case must be dysfunctional to be accepted for treatment, Participants whose molars and bicuspids are in good occlusion seldom qualify. INTERCEPTIVE ORTHODONTICS IS NOT A COVERED BENEFIT. Crowding alone is usually not dysfunctional in spite of the aesthetic considerations. The PARTICIPANT MUST HAVE LOST ALL PRIMARY TEETH AND HAVE PERMANENT TEETH ERUPTING OR IN OCCLUSION TO BE CONSIDERED.

All orthodontic services require prior authorization by a DentaQuest Consultant. Requests for prior authorization need to include:
* Orthodontic examination and records
* Appropriate radiographs and facial photographs
* Detailed treatment plan with diagnosis and prognosis

The fee for the initial exam, radiographs and study models should be submitted under procedure code D8660.

DentaQuest will reimburse doctors for orthodontic records when denial determinations are made. It is the responsibility of the rendering office to submit a claim for the payment of orthodontic records, as DentaQuest cannot generate claims on the behalf of its network doctors. Claims for orthodontic records payments must be: made in accordance with timely filing protocols, submitted on a HIPAA compliant ADA claim form, billed using CDT code D8660, and have history of a DentaQuest denied orthodontia request on file. As with all claims for payment, orthodontic records are subject to member eligibility, frequency, and benefit limitations outlined herein and in accordance with State regulations.

The starting and billing date of orthodontic services is defined as the date when the bands, brackets, or appliances are placed in the Participant’s mouth. It is important to verify the Participant’s eligibility, as the Participant must be eligible on this date of service.

Payment for orthodontics includes all appliances, retainers and all follow-up visits. Orthodontic appliance benefit limited to once per lifetime.

To initiate payment on an approved comprehensive orthodontic case, the dental office needs to submit a claim form indicating the date the appliances were placed (banding date). Monthly payments will be made for approved treatment as long as the Participant remains eligible and is in active treatment. IN ORDER TO RECEIVE REIMBURSEMENT FOR MONTHLY ADJUSTMENTS, PROVIDER MUST BILL FOR THE DATE OF SERVICE TREATMENT WAS RENDERED. A Participant will not be considered to be in active treatment if they have failed to keep appointments in two consecutive months. If a Participant fails to keep an appointment for two consecutive months, the dental office must notify DentaQuest.

Continuation of orthodontic care will be handled in the following fashion:

1.For cases started when the member was on Fee For Service Medicaid, DentaQuest will attempt to secure the original pre-treatment records for review by a DentaQuest Consultant. The original records will be reviewed using the criteria for all new cases. If the original records pass the test of medical necessity, a continuation of benefits based on a pro-rating of the treatment remaining will be paid.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

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Orthodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D8080	comprehensive orthodontic treatment of the adolescent dentition	2 - 20		Yes	One of (D8080) per 1 Lifetime Per patient.	
D8660	pre-orthodontic treatment examination to monitor growth and development	2 - 20		Yes	One of (D8660) per 6 Month(s) Per patient.	
D8670	periodic orthodontic treatment visit	2 - 20		Yes	One of (D8670) per 30 Day(s) Per patient.	

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Adjunctive general services include general anesthesia, intravenous sedation, nitrous oxide analgesia, consultations and various drugs and medicaments, and emergency services provided for relief of dental pain.

Procedure code D9110 – palliative treatment is to be used to bill for minor palliative procedures when the only other procedure code billed for is a diagnostic radiograph. If any other services (filling, endodontics, oral surgery etc.) are billed for on the same day, the palliative treatment code will be denied. Intravenous sedation and general anesthesia will only be a covered service for participating dentists that hold current certification and licensure per state and federal guidelines. Requests for intravenous sedation and general anesthesia will be reviewed on a case by case basis. A case will be covered for Participants with physical or mental health problems of such severity that treatment can not be reasonably attempted without the use of intravenous sedation or general anesthesia.

Intravenous sedation or general anesthesia may be allowed when a surgical procedure is being rendered. Claims for intravenous sedation and general anesthesia must include a narrative of medical necessity. Acceptable conditions include:

* Toxicity to local anesthesia supported by documentation;
* Severe mental retardation;
* Severe physical disability;
* Uncontrolled management problem;
* Extensive or complicated surgical procedures;
* Failure of local anesthesia;
* Documented medical complications; and
* Acute infection that would preclude the efficacy of local anesthesia.

For cases requiring intravenous sedation or general anesthesia, Providers must document the following in the Participant's chart for appropriate psychosomatic disorders: diagnosis, description of past evidence of situational anxiety or uncontrolledbehaviors, and in the case of referral due to uncontrolled behavior, the name of the referring dentist or provider group. Apprehension alone is not typically considered medically necessary. DentaQuest or the IDPA may elect to perform chart audits on these services. Services not documented as required may be denied for payment. The procedures will only be reimbursed for once per day regardless of the length of time it takes to complete the procedure.

General anesthesia, intravenous sedation, and nitrous oxide are only covered in conjunction with a covered dental procedure. Payment for any one of these services precludes payment for the remaining procedure codes. Payment for general anesthesia or intravenous sedation includes any other drugs administered on the same day.

Reimbursement for local anesthesia is included in the fee for the procedures.

Procedure code D9230 – nitrous oxide, is a covered service for Participants who are mentally or physically challenged, or otherwise present with special management needs. Special consideration is granted to individuals under the age of six that require extensive dental treatment and/or exhibit rampant caries where patient management is a concern.

Only claims for nitrous oxide with documented medical necessity will be considered for payment. Medical necessity for the use of nitrous oxide would be broadly defined as some condition. Some examples of conditions that would establish medical necessity for nitrous oxide are:

* Apprehensive child under the age of six when any treatment is rendered

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* Apprehensive children between 6 and 10 years of age when restorative or surgery is performed
* Apprehensive children between the ages of 10 and 18 years when surgical services are performed

All other situations for nitrous oxide will be reviewed for coverage on a case by case basis.

Procedure code D9310 – consultation, will only be reimbursed to a dentist other than the one providing definitive treatment. A consultation includes an examination and evaluation of the patient, and a written report from the consultant to the treating dentist. When billing for a consultation, a copy of the written report must be attached. When the consulting dentist also performs services reimbursement to that dentist will be limited to the actual services performed. There will not be a separate reimbursement for a consultation.

Procedure code D9999 is to be utilized to submit a request for reimbursement for a dental service not otherwise described herein. Request should include a description of the service, medical necessity, a proposed fee and any pertinent radiographs.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9110	palliative (emergency) treatment of dental pain - minor procedure	0-20		No		
D9222	deep sedation/general anesthesia – first 15 minutes	0-20		Yes	One of (D9222) per 1 Day(s) Per patient. Not allowed in conjunction with D9230, D9239, D9243, D9248 or D9920.	narrative of medical necessity
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment	0-20		Yes	Eight of (D9223) per 1 Day(s) Per patient.	
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	0-20		No		
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	0-20		Yes	One of (D9239) per 1 Day(s) Per patient.	narrative of medical necessity
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	0-20		Yes	Eight of (D9243) per 1 Day(s) Per patient.	
D9248	non-intravenous moderate (conscious) sedation	0-20		Yes		
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	0-20		Yes	Hospital Consultation Only. Should be billed in 30 minute increments. Limit of 6 D9310 per hospital admission.	
D9420	hospital or ambulatory surgical center call	0-20		Yes	Should be billed in 30 minute increments. Limit of 6 D9420 per hospital admission.	
D9440	office visit - after regularly scheduled hours	0-20		No	Two of (D9440) per 1 Year(s) Per patient.	

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Exhibit F Benefits Covered for
Amerigroup Georgia Families 360° Medicaid

Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9610	therapeutic drug injection, by report	0-20		Yes		
D9630	other drugs and/or medicaments, by report	0-20		Yes		
D9920	behavior management, by report	0-3		No	Sixteen of (D9920) per 1 Year(s) Per patient. To be billed in 15 minute increments. Allowed only for patients 3 years of age or younger, or are handicapped or special needs who cannot be managed or handled in the routine dental office setting through normal office procedures.	
D9920	behavior management, by report	4 - 20		Yes	Sixteen of (D9920) per 1 Year(s) Per patient. To be billed in 15 minute increments. Allowed only for patients 3 years of age or younger, or are handicapped or special needs who cannot be managed or handled in the routine dental office setting through normal office procedures.	

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